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ABSTRACT

A program was developed in Virginia to train Black and rural family caregivers of persons with dementia, particularly Alzheimer's disease. This final program report begins with project briefs that summarize major products and findings, program objectives and accomplishments, and dissemination activities. Chapter 1 addresses issues related to dementia and caregiving in Black and rural communities. Chapter 2 describes activities related to program objectives, including forming partnerships with organizations and community members who helped develop the training curriculum, developing the training package, implementing the "train the trainer" model, evaluating the project, and developing the replication plan. Chapter 3 summarizes results of program evaluation. The 69 community leaders who participated in training gained significant knowledge about implementing workshops for family caregivers and rated the training highly. The 208 family caregivers who attended workshops given by the 69 community leaders also gained significant knowledge and judged the workshops to be useful and relevant. The last chapter discusses additional program outcomes related to community collaboration, outreach strategies, capacity building, and evaluation. Appendices include suggested readings for trainers and caregivers; directories of community resources in Central and Southside Virginia; forms necessary for program implementation; results of nominal group process for regional needs and resource teams from central and southside Virginia; and evaluation reports for first-level training (trainers), second-level training (trainees), and comparison of full and abbreviated training programs. These reports contain all forms necessary for program evaluation including pretest and posttest questionnaires. (LP)

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Families Who Care

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Assisting African American and Rural Families Dealing with Dementia

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Final Report

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Assisting Black and Rural Caregivers of Elders with Dementia:

Progressive Training Through Trusted Resources

Final Report
Submitted to the U.S. Administration on Aging

Grant #90AT0525
November 30, 1994

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For the participation of other colleagues in the aging network who volunteered to devote significant time and effort in advising project staff, assisting in the recruitment of trainers and caregivers, participating in the training events, and contributing to the creation of project products, we are much indebted.

We would be remiss not to mention our trainers who volunteered to be the recipients of our instruction, master the training manual, and conduct caregivers workshops. These community leaders, who so generously gave of their time so that others could benefit, constitute the manual's raison d'etre. We cannot thank them enough for their willingness to participate in the project and provide education for caregivers.

We are especially grateful to the African American and rural family caregivers who attended the community workshops. Their willingness to share their joys and sorrows with other caregivers and the project's trainers enriched the experience for all involved. The efforts of the project staff, advisory groups, and trainers were intended only to support these faithful, seemingly tireless individuals.

Finally, we wish to acknowledge the efforts of family caregivers everywhere. It is primarily through their courage, strength, and selfless determination, that older adults with disabilities can remain in the homes continuing to enrich the lives of their loved ones and others in the community.

PROJECT BRIEFS

PROJECT BRIEFS
Table of Contents

HIGHLIGHTS OF PROJECT OUTCOMES

A. Major Products

B. Major Findings

EXECUTIVE SUMMARY

A. Objectives and Accomplishments

B. Products Developed
    1) The Training Manual
    2) The Replication Plan
    3) The Resource Directories

C. Program and Policy Implications

D. Recommendations

DISSEMINATION SYNOPSIS

HIGHLIGHTS OF PROJECT OUTCOMES

A. Major Products

Training Manual. Families Who Care: Assisting African American and Rural Elders Dealing with Dementia is a substantial training manual designed to train family caregivers of persons with dementia, especially those in African American and rural communities. The first part of the manual (training for trainers), educates potential trainers about dementia, rural issues, ethnic competence, adult learning theory and organizing a training group. An extensive list of references accompanies each chapter as well as tips for trainers, suggestions for outreach, and sample press releases. The second part (training for caregivers) consists of comprehensive lesson plans that are organized in modular format and "stand alone" so that trainers can select the particular modules which the fit the needs of a particular group. The lesson plans are sequenced according to the progression of dementia, graded for literacy appropriateness (tenth grade, on the average), and edited for cultural sensitivity.

Replication Plan. The Replication Plan for the project is organized around four basic components or outcomes: collaboration, outreach, capacity-building, and evaluation. Those who replicate this project through the components of the Integrated Model Plus (IMP) will not only achieve these stated outcomes, but will also learn much about establishing linkages, networking in African American and rural communities, and developing community expertise to strengthen caregiving families.

Resource Directories. The project distributed brief directories of regional community resources to caregivers who attended community workshops and more extensive directories to the trainers of caregivers. A directory of helpful National organizations, including a number concerned with minority aging issues, and a Virginia State directory are available on disk (3 1/2 inch, double density, 720K, IBM formatted in ASCII).

B. Major Findings

Evaluation of First Level Training Report. This report details the analytical results of evaluation efforts to assess the utility of two full days of training provided to 69 trusted community leaders preparing to offer caregiver workshops in their respective communities. Statistically significant gains in knowledge were demonstrated and the training was well-received with high marks in all areas of evaluative inquiry. The report also compares evaluation outcomes and different sites and among trainers with different demographic characteristics. Item analyses resulted in revised pre-training and post-training knowledge questionnaires.

Evaluation of Second Level Training Report. This report presents analyses of evaluation data received from trainers and provided by 208 caregivers attending educational workshops. Statistically significant gains in knowledge were demonstrated for all nine required content areas and the workshops were judged to be useful and relevant. Caregivers indicated that they gained increased understanding of themselves and their care recipients. They also became more aware of and more likely to access help available in their communities.

EXECUTIVE SUMMARY

A. Objectives and Accomplishments

Objective I: To form a partnership of the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia, to be called Regional Needs and Resources Teams (RNRTs).

Regional Teams in Central (37 members) and Southside Virginia (24 members) were established and advised project staff concerning the educational needs of caregivers and resources available in the targeted regions. RNRTs were comprised of the most relevant and significant organizations that might address the continuing needs of targeted caregivers. Faculty members at Historically Black Colleges and Universities, representatives from relevant state agencies (e.g., Aging, Health, & Mental Health), local service agencies (e.g., area agencies on aging, adult day care centers), two Alzheimer's Association chapters, and statewide/regional church organizations all participated as project advisors.

Resource Teams were an integral part of the project since its inception. They initially guided project staff in identifying the training needs of the family caregivers by participating in a modified nominal group process. RNRT members also advised project staff about the barriers which have traditionally prevented rural and Black caregivers from taking advantage of educational opportunities and ways to engage Black caregivers in the training. Later RNRT members contributed to the writing and editing of the training manual, assuring that the manual was culturally sensitive and literacy appropriate. Some members participated in the training of trainers by serving on community resource panels providing local expertise and discussion of services available to family caregivers. The RNRT membership assisted project staff in the recruitment of appropriate trainers to provide caregiver education. Other members volunteered to serve as Access Resource or Caregiver Contact participants assisting trainers in the recruitment and identification of family caregivers.

Objective II: To develop a comprehensive, culturally sensitive training package targeted to caregivers of elders with dementia that is organized according to the progression of cognitive, social, and behavioral impairment.

The training package consisted of the training manual, resource materials used during the two-day training sessions (pertinent handouts, brochures, & pamphlets), a suggested reading list, and caregiver resource directories listing particular to the targeted localities in Central and Southside Virginia. The training manual explains in detail, exactly how to recruit caregivers, find a meeting site, and publicize the workshops. It provides step-by-step instruction on how to conduct caregiver workshops, and a Chapter on adult learning theory. It also includes evaluation instruments, along with supplementary reading material and reference lists for advanced preparation. Special Chapters on cultural sensitivity and outreach to African American and rural populations are included. Information contained in the 19 Caregiver Lesson Plans or modules has been graded for literacy appropriateness and edited for cultural sensitivity.

Objective III: To implement and test the "train-the-trainer" model as a mechanism for caregiver education.

The train-the-trainer approach was applied at the local community level to effect a large-scale increase in expertise and knowledge. Caregivers became more knowledgeable about dementia and the community resources available to them, resulting in a better quality of life for them and the elders they care for.

A total of 69 trainers were initially trained. Of these, 49 trainers proceeded to complete workshops to educate family caregivers. They spent 8.35 hours per trainer in contact with 208 family caregivers. In total, trainers contributed 1,341.5 person-contact hours to the project, in addition to the effort required to recruit participants, organize and plan the workshops, and prepare Lesson Plans.

The project recruited trainers of caregivers who were: 1) knowledgeable of caregiver issues, especially caregiving for dementia victims; 2) in touch with caregiver networks locally (Area Agencies on Aging, Social Services, local Long Term Care Coordinating Committees, Alzheimer's Association chapters, faith communities, support groups, etc.); 3) able to translate the training manual into a successful training experience for caregivers; and 4) knowledgeable of caregiver training needs and means of recruiting potential caregiver trainees.

Project staff were continually available to aid in the recruitment of caregivers for trainers who had difficulty. Outreach social workers, Area Agencies on Aging staff, faith community leaders, and personal contacts were all ideal resources. Although many trainers had little or no difficulty involving family caregivers since they were well-known, trusted, and respected in their communities, others wrestled with persistent obstacles such as motivational and time constraints which prevented caregivers from fully participating. Some trainers simply could not persuade over-burdened caregivers of the advantages of attending educational seminars. Reluctance to leave their loved ones in the care of others also proved to be an obstinate obstacle. Although eventually achieving some degree of success through persistence, these trainers underestimated the amount of time and effort required for recruitment. On the other hand, some caregivers were introduced to the benefits of respite as a consequence of their involvement in the project and continued to access community resources after the workshops concluded. As the project concludes, staff are gratified by the many ways in which activities initiated by the project are continuing. There is no doubt that the project succeeded in building the capacities of trusted community resources as known and active experts in the area of Alzheimer's caregiving.

To enable and encourage attendance, the project reimbursed caregivers for adult day care, respite care, and transportation if needed. Trainers were also reimbursed for expenses incurred. Project staff found that in general, subsidized respite care was either not needed or not wanted. In some cases, trainers had difficulty encouraging caregivers to take advantage of the respite support available to allow them to attend the workshops.

Workshops were organized to correspond with the progression of dementia. The first workshops dealt with earlier issues, then the content proceeded to be related to more problematic symptomology associated with the middle stages of dementia, while the last workshops provided information relevant to the late stages of dementia. In this way, caregivers could get the information they needed, when they needed it most. Unsolicited feedback from some trainers pointed to the rewarding aspects of altruistic efforts and their satisfaction with the workshop experience.

Objective IV: To evaluate the project and disseminate findings for replicability beyond the project period and beyond the geographical regions.

Formative Evaluation: Results from RNRT Nominal Group Process

Initially the project received feedback from the Central and Southside RNRT members regarding the extent to which the nominal group process was successful in identifying curriculum content. In each group, all but one of the respondents rated the process as "Very Successful." RNRT members received the results of the nominal group process summarizing the ranked topic categories and the suggested ideas which were included within each category. They were asked if "there are any other important training topics or information useful to family caregivers, not mentioned on the enclosed list of results, that should be included in the training curriculum?" Most respondents indicated that the nominal group process had resulted in a very comprehensive list of topics, and they could not think of any omissions.

Summative Evaluation: Results of First Level Training (Training of Trainers)

Trainers were predominantly African American and disproportionately female. The majority worked or practiced in a rural area. They tended to be well-educated, with almost half possessing advance degrees. Almost one-quarter were social workers, and more than one-quarter were nurses. The training was well-received, with high marks in all areas of evaluation.

Statistically significant gains in knowledge were demonstrated for both training days. Item analyses revealed that only two of the items on the first-day knowledge test, and four of the items on the second-day knowledge test, were judged to have little discriminative ability. Internal reliabilities were acceptable, given the abbreviated length of the knowledge tests and the limited sample sizes employed.

Site comparisons of knowledge gains achieved indicated that the most remote, rural site performed least well. Participants at the urban site performed better on the second training day than trainers at the other sites. In general, rural participants failed to provide correct answers to about one-third of the post-training test items, while trainers at the urban and mixed sites scored correctly on three-quarters of the knowledge test items.

An examination of other comparisons of trainers resulting in statistically significant knowledge gain differences revealed that: 1) non-minority participants scored better than African American trainers, 2) trainers with four-year degrees out-performed those without degrees, and 3) urban practitioners showed greater knowledge gains than rural practitioners.

Several differences between trainers were noted with respect to their evaluation of the training. In general: 1) trainers at the rural sites provided higher ratings than those at the urban or mixed training sites, 2) African American trainees valued the training more highly than Caucasians, 3) participants with Bachelor degrees regarded the training content as more effective than those with advanced degrees or those without four-year degrees, and 4) nurses thought the training materials were of higher quality than either social workers or those in other disciplines.

Summative Evaluation: Results of Second Level Training (Caregiver Workshops)

Of the 165 caregivers who completed evaluations of the workshops, almost three-quarters of respondents were African Americans and the majority (about 85%) were women. Almost three-quarters lived in rural areas. To demonstrate knowledge gains, pre-workshop and post-workshop questionnaires were administered. Percentage scores were calculated by dividing the total knowledge score by the number of items answered.

Prior to the mini-lecture, the average percent score was 61.47% (S.D. = 12.30). That is, participants answered 21.55 of the 59 questions correctly on the average. After training, average percent scores increased to 74.03% (S.D. = 14.28) or 26.30 items correct on the average. This constituted **a statistically significant gain in knowledge** (t = 13.54; p= .0001).

The results of the Workshop Evaluation Questionnaires indicate that the workshop content was relevant to the personal problems and concerns of caregivers. Caregivers learned a great deal about AD, caregiving, and other information included in the mini-lectures for each of the Caregiver Lesson Plans. They became more aware of community resources available to help them with their caregiving responsibilities and, as a consequence of attending the workshops, they are more likely to access the available help.

Monitoring Caregiver Workshops

Approximately 10% of the caregiver training sessions were monitored by project staff to ensure that the training package protocol was implemented properly. Although there was considerable variation among trainers in their teaching style and techniques employed, it was apparent that trainers had spent some time reviewing the introductory Chapters of the training manual and had incorporated that awareness into their instruction. They had become completely familiar with the supportive service agencies in their communities as a consequence of their training, and freely translated their knowledge to the caregivers who could take advantage of the help available to them.

B. Products Developed

The major products resulting from grant activities include the training manual, Families Who Care: Assisting African American and Rural Families Dealing with Dementia, the Replication Plan (or Project Developer's Guidelines), and the four (4) Resource Directories (National, State, Central Virginia, and Southside Virginia).

1) The Training Manual

The training manual, Families Who Care: Assisting African American and Rural Caregivers Dealing with Dementia, is a substantive training tool for educating family caregivers of persons with dementia, especially those in African American and rural communities. The training manual was field tested with 69 community leaders (members of the clergy, nurses, teachers, social workers, etc.) who, in turn, provided community workshops for over 200 family caregivers in African American and rural communities in Central and Southside Virginia. The manual is organized in two parts. Part I has an Introduction and five (5) chapters designed to educate trainers about dementia, ethnic competence, rural considerations, adult learning theory, and how to conduct workshops. Most chapters include lists of supplementary reading material and reference lists for advanced preparation.

Part II contains 19 Caregiver Lesson Plans, organized in modular format. The Caregiver Lesson Plan modules "stand alone" so that trainers can tailor their workshops to fit the particular educational needs of family caregivers. Because research indicates that caregivers are more willing to attend educational workshops when they feel that their unique concerns will be addressed, the lesson plans are organized to correspond roughly with the progression of dementia. When marketing the series, potential participants are informed that they can choose to attend only those workshops which directly pertain to their personal caregiving situation. For example, the first workshop can be structured to deal with issues important when symptoms first become apparent, while the second workshop covers problems that arise later on in the illness and the third workshop targets topics important during the end stages. For example, suggested modules to be covered during the first workshop include: An Overview of Dementia and Caregiver Issues, Caregiver Burden, Coping with Stress, and Legal and Financial Issues. Some modules included in the middle stages section are: Managing the Daily Routine, Safety & Environmental Adaptations, Using Formal Supports and Resources, and Managing Resistive Behavior Associated with ADLs. Content most relevant to the later stages are Maintaining Urinary Continence and 24 Hour Care.

Each module includes a stated goal, rationale, educational objectives, detailed mini-lecture, suggested readings and audio-visual reinforcement, experiential learning exercises, and hand-out materials to be distributed. Each mini-lecture has been graded for literacy appropriateness (tenth grade reading level on the average) and edited for cultural sensitivity.

Although the manual was created for use by trainers targeting African American and rural caregivers, much of the information is more generally applicable for non-minority caregivers or those in urban or suburban areas. The manual can also be selectively used with caregivers who have care recipients that are not experiencing cognitive deficits by abstracting the information common to all family caregiving situations. Finally the utility of the manual extends beyond the audience of informal caregivers and can be easily adapted for use with formal caregivers.

2) The Replication Plan

The Replication Plan for the project, "Assisting Caregivers of Black and Rural Elders with Dementia: Progressive Training Through Trusted Resources," is based upon the Integrated Model for Collaborative Planning and Services to Older Adults with Developmental Disabilities(AoA grant #90AM0680/01) directed by Edward F. Ansello, Ph.D and awarded to the Virginia Department for the Aging. The Integrated Model is a broad, tested process strategy that is relevant for addressing the needs of people who live in the community rather than in institutional settings. As initially conceptualized the Integrated Model has three components: 1) collaboration, 2) outreach, and 3) capacity-building. The Integrated Model Plus (IMP) adds a fourth component, Evaluation. All four components should be incorporated into any replication of this project. A brief discussion of these four outcomes provides a rationale for replicating the project.

Collaboration. One of the main objectives of the project was to form a partnership of the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia. The Replication Plan describes appropriate partners to involve and the ways in which these individuals can facilitate project activities. From guiding the content of the training manual to the recruitment of trainers and caregiver participants, the collaborating partners provide a firm foundation upon which the project can build.

Outreach. The need for outreach to rural and African American caregivers is well-documented in the manual's Chapters. The attendant barriers to service utilization among these two special populations, important considerations to any outreach effort, were addressed as the project sought to increase the likelihood that caregivers would access formal supports. Trainers were trained to function as advocates, in a sense, directing and guiding caregivers to access the formal resources available to them in their communities. The Replication Plan describes a variety of recruitment efforts undertaken and how the involvement of trusted community leaders can offset the further challenge presented by the colloquial stigma attached to dementia and Alzheimer's Disease.

Capacity-building. Another major objective of the project was to implement and test the "train-the-trainer" model as a mechanism for caregiver education. The Replication Plan details how project staff accomplished this objective by directly developing the capacities of trusted community leaders who served as trainers of caregivers, by indirectly improving the capacities of caregivers through the conduct of workshops, and by subsequently increasing the ability of elders with dementia to remain, as appropriate, in their communities and avoid premature institutionalization. Those who replicate the project will employ the train-the-trainer model to allow the expertise imparted to endure beyond the scope of the project with those in the community who were trained to conduct workshops and empowered to do so via the training manual materials.

Evaluation. Evaluation is a significant component of the IMP. The Replication Plan includes all questionnaires and forms used to evaluate the project. Since all project activities (e.g., recruitment of trainers and caregivers, first and second level training) stem from successful collaboration, formative evaluation provides an effective method of establishing relevant training curricula and assuring that all appropriate partners are involved. The Replication Plan also delineates the advantages of conducting a summative evaluation of the first and second levels training.

Those who replicate this project through the components of the Integrated Model Plus will not only achieve these stated outcomes, but will also learn much about establishing linkages, networking in African American and rural communities, and developing community expertise to strengthen caregiving families.

3) The Resource Directories

In addition to the Resource Directories distributed to the caregivers who attended workshops, four other Resource Directories were created. Two Directories were created for use by the trainers in the two target areas of the State (i.e., Central and Southside Virginia). These two directories were distributed to all trainers, but will be especially helpful to those in the fields of Mental Health, Social Work, Health and Aging. For any trainer who is or became an advocate for caregivers of elders with dementia as a consequence of their participation in the project, the resource directory will be an invaluable tool. Two other directories were created for purposes of National and Statewide dissemination. These directories are offered on diskette (3 1/2 inch, double density, 720K, IBM formatted in ASCII) so they can be updated and addended over time as information changes and new resources become available. A directory introduction contains a description of community services that are appropriate to the needs of persons with dementia as the disease progresses. As informational tools especially helpful for those who advocate for caregivers of elders with dementia, the directories also have more general utility for other aging advocates and service providers as well.

C. Program and Policy Implications

Implications Related to All Family Caregivers

1. The single greatest contribution made by this project is in demonstrating the utility of an informal model of intervention with caregiving families of elders with dementia. Educational programs, delivered by trusted community leaders, can provide simple, basic information which can enhance family caregivers' abilities to provide better quality care and prevent premature institutionalization of their loved ones.

2. Although training in self-advocacy was not a primary intent of this project, caregivers indicated that, as a result of their participation in the training workshops, they are now more likely to access available help, both formal and informal. Helping caregivers to understand formal service systems and how they can be utilized to improve the way in which they provide care to their family members enables informal caregivers to become better advocates for themselves and their care recipients.

3. Policy makers need to be educated about the contributions to health care made by family caregivers of elders with dementia and the extent to which cost-savings can be achieved through strengthening home and community based care systems of support. Elderly care recipients, who generally do not need skilled nursing care, should be allowed to remain with their loved ones in the community for as long as appropriate.

4. This project demonstrated the importance of insisting that any health care reform plan that is enacted include a strong long-term care component related to respite. It is only through the provision of respite (which can range from adult day care to companion care to brief accommodation in a residential facility) that caregivers become capable of attending to their own mental and physical health before continuing to accept their sometimes overwhelming responsibilities.

5. Realizing the tremendous personal sacrifices that caregivers make in order to care for their dependent elderly family members, there is a need for more concerted and aggressive advocacy efforts to increase the availability of home and community based services to support family caregivers. Informal community leaders who are not already aware of the needs of caregiving families must be informed and convinced to devote some of their resources to meeting the imperative of quality care for community-dwelling elders with Alzheimer's Disease.

6. In general, there is a need to raise the public consciousness about the importance of maintaining at-risk elders in the community and provide greater support for those who make it possible, i.e., family caregivers. Only when the community at large has been educated about the need to support family caregivers, will it be possible to catalyze a collective movement for action. Public education to spread the word about the social benefits inherent in assisting families in their Herculean efforts is a necessary first step in any "grass roots" movement.

Implications Specific to African American and Rural Family Caregivers

1. The failure of efforts to transfer the urban, majority, middle-class model of support groups to rural and minority populations is well-known. This project demonstrated that educational support groups, conducted by individuals who are respected as informal leaders in their communities, can successfully be used as an intervention with African American and rural family caregivers.

2. The basic distrust of formal service systems common to both African American and rural caregivers can be countered by training trusted community leaders who have the persuasive ability to change these dysfunctional and counterproductive attitudes. The results can be seen as caregivers learn to be better advocates for themselves and their care recipients.

3. This project demonstrated the importance of churches as sources of support for families who are providing care for dependent elders. Many, if not most, of the informal community leaders who served as trainers for this project were affiliated with churches. Although trained as social workers or nurses, they volunteered to serve as trainers, not because of their disciplinary backgrounds, but because of the specific roles they played in their churches. Some had formal roles in ministry, while others, particularly African Americans, recognized that their education and informal leadership positions gave them special responsibilities for stewardship.

4. The unique strengths in caregiving patterns in minority communities can be utilized to support family caregivers. To the extent that African American and rural caregivers tend to have a greater reliance on familial and fictive kin, these family and community supports can be strengthened by educating caregivers and encouraging them to access appropriate resources.

5. Targeted educational programs designed to impart preventive and maintenance approaches to health care can teach families to avoid the crisis reaction approach which is currently prevalent among families isolated in rural communities or those without family physicians or adequate insurance. Learning the importance of continuity of care may help to reduce the expensive use of emergency rooms and clinics where proper follow-up is not provided.

D. Recommendations

1. Achieve a fair system of financing long term care that assures access to appropriate and affordable quality care at home, in the community and in residential care settings for all persons with Alzheimer's Disease and other dementias, regardless of ethnicity or geographical location.

2. Increase the development of educational materials that are both literacy appropriate and culturally sensitive and promote their dissemination through aggressive outreach in African American and rural communities.

3. Develop and distribute public service advertising and other marketing communication materials to reach isolated, rural and diverse multicultural audiences.

4. Encourage and facilitate the community outreach and educational efforts of rural hospitals and nursing homes to support family caregivers of elders with Alzheimer's Disease and other dementias.

5. Provide an active, concerted program of education for members of the clergy in African American and rural communities to enhance their spiritual leadership abilities in support of families dealing with Alzheimer's Disease and other dementias.

6. Further research efforts should be directed toward an empirical examination of the extent to which social class, ethnocultural, and racial factors influence access to and utilization of formal community resources which support family caregivers of elders with dementia.

7. Further research efforts should systematically examine the barriers to service utilization among family caregivers in isolated, rural areas and develop strategies for overcoming those obstacles.

DISSEMINATION SYNOPSIS

The Virginia project, "Assisting Black and Rural Caregivers of Elders with Dementia: Progressive Training Through Trusted Resources," utilized a "train-the-trainer" approach, relying on trusted community leaders to identify and recruit African American and isolated, rural caregivers in local communities and provide workshops to improve their caregiving abilities and increase the likelihood that community resources would be accessed. A detailed, comprehensive training manual edited for cultural sensitivity and graded for literacy appropriateness was developed to initially train and serve as a guide for community workshop facilitators. Because the project began by forming partnerships with the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia, the project became well-known and generated considerable interest among faculty members at Historically Black Colleges and Universities, representatives from relevant state agencies (e.g., Aging, Health, & Mental Health), local service agencies (e.g., area agencies on aging, adult day care centers), two Alzheimer's Association chapters, and statewide/regional church organizations.

A variety of techniques was used throughout the duration of the project to disseminate educational products developed, program methodology, and findings. Dissemination began with a press release mailed to approximately 350 state, regional, local aging agencies, and appropriate newspapers in the targeted areas of the State through the Virginia Commonwealth University (VCU) office of Media Relations. The project was continually featured in "AGE in Action," the quarterly newsletter of the Virginia Center on Aging and the Virginia Geriatric Education Center beginning with the December, 1992 issue (circulation approximately 2,000). The newsletters of the Greater Richmond Chapter of the Alzheimer's Association (circulation approximately 1,000) and the Southside Chapter (circulation approximately 400) also included articles about the project. VCU's President Trani introduced the project to University faculty in his in-house memo, "Across the President's Desk." Members of the project's two advisory groups also offered to feature the project in their respective publications. Over the course of the project, articles appeared in the following print media:

1) Office of Health Care Policy and Research Directory - Medical College of Virginia
2) Gerontology News - newsletter of the Gerontological Society of American (October, 1994)
3) Virginia Health Care Association Memo (July 15, 1993)
4) Adult Services News - Va. Dept. of Social Services (October, 1993)
5) The Golden Herald - Lake Country Area Agency on Aging rural newsletter (Sept/Oct., 1993)
6) The News & Record - rural South Boston newspaper (April 5 & 7, 1993)
7) The Sun - rural Clarksville newspaper (February, 1994)
8) Richmond Times Dispatch (March 27 & 28, 1994)
9) Gazette-Journal - rural Gloucester newspaper (February 26, 1994)
10) Farmville Herald - rural newspaper (December 31, 1993)
11) Virginia Association for Home Care newsletter (January, 1993)
12) Institute for Disability Studies newsletter of the University of Southern Mississippi (Summer, 1994)
13) The Southern Gerontologist (Winter, 1995)
14) AGHE Exchange - newsletter of the Association for Gerontology in Higher Education
15) Suburban Area Agency on Aging publication in Oak Park, Illinois (October, 1994)

Although the project staff discovered early in the project that word-of-mouth advertising or networking and face-to-face meetings were the most productive means of publicizing the project, there was one attempt to utilize the electronic media as a means of dissemination and recruitment. A Richmond television station (WRIC) devoted part of their aging segment on the noon news to publicize the pending workshops for caregivers during the fourth quarter of the project. As if confirming the co-directors conviction, the effort was singularly unproductive.

Thousands of announcements about the project and the training opportunity were distributed to members of the clergy in rural churches. These were used by trainers in their outreach and recruitment of caregivers. Similarly, hundreds of flyers were produced and posted by trainers in key locations where caregivers might frequent. Memoranda to caregiving families informing them of the workshops being planned was sent (along with project flyers) in routine mailings from various service organizations such as the Capital Area Agency on Aging, Family and Children Services, and the office of Family and Work Resources at VCU.

In addition to project advisory group meetings and other planning and recruitment meetings specifically called in pursuit of project objectives, the project staff took advantage of every opportunity to include information about the project, the training opportunities, and the impending availability of project products in ancillary speaking engagements. Forums included:

1) Monthly steering committee meetings of the Central Virginia Caregiver Advocates, formed as a part of Project Care, Virginia's response to Commissioner Berry's Eldercare Campaign initiative.
2) Quarterly Board of Directors meetings of the Virginia Association on Aging
3) Quarterly meetings of the Interfaith Coalition for Older Virginians
4) Quarterly meetings of the Virginia Coalition on Aging
5) The annual Legislative Breakfast of the Virginia Center on Aging (VCoA) - January 21, 1993 & January 20, 1994
6) Governor's Commission on Alzheimer's Disease and Related Disorders - January 12, 1993
7) Department of Information Technology luncheon - February 17, 1993
8) John Tyler Community College - February 23, 1993
9) Commonwealth Coalition for Alzheimer's Advocacy - March 9, 1993
10) St. Matthew's Church Nutrition Site - March 12, 1993
11) Alzheimer's Association - Greater Richmond Chapter Volunteer Recognition Ceremony - April 18, 1993
12) Senior Adult Retreat at the Eagle Eyrie Baptist Conference Center - May 4-6, 1993
13) Central Virginia Chapter of the Black Nurses Association - June 15, 1993
14) Guest lecture in graduate gerontology course - March 29, 1993
15) Nursing workshop sponsored by the Va. Geriatric Education Center - August 24, 1993

Project staff also presented the project, its products, and findings at numerous state, regional, and national professional meetings including:

1) Celebrating Diversity Series hosted by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services - February 8, 1994

2) Belle Boone Beard Gerontology Center Annual Conference - April 11, 1994
3) 46th Annual Scientific Meeting of the Gerontological Society of America - November 21, 1993
4) 15th Annual Meeting of the Southern Gerontological Society - April 22, 1994
5) 12th Annual Meeting and Conference of the Association for Gerontology and Human Development in Historically Black Colleges and Universities - February, 1994
6) Joint Meeting and Conference of the Virginia Coalition on Aging and the Virginia Association on Aging - December 2-3, 1993 and December 1-2, 1994
7) 49th Boule of Chi Eta Phi Sorority , Inc. - July 13, 1994

Most recently dissemination activities have focused on distribution of the project products. Products available from the Virginia Center on Aging include:

Training Manual. Families Who Care: Assisting African American and Rural Elders Dealing with Dementia is a substantial training manual designed to train family caregivers of persons with dementia, especially those in African American and rural communities. ($15.00 per copy)

Replication Plan. Organized around four basic components or outcomes: collaboration, outreach, capacity-building, and evaluation, those who replicate the project achieve the stated outcomes, and learn much about establishing linkages, networking in African American and rural communities, and developing community expertise to strengthen caregiving families. ($5.00 per copy)

National Directory of Resources. A resource directory/diskette of helpful National organizations, including a number concerned with minority aging issues is available (3 1/2 inch, double density, 720K, IBM formatted in ASCII). ($10.00 per set-hardcopy & diskette)

State Directory of Resources. A Virginia State resources directory/diskette including: Adult Day Care Centers, Alzheimer's Association and Chapters, Area Agencies on Aging, Health Departments, Home Health Care, Homes for Adults, Information and Referral Centers, Mental Health Facilities, Nursing Homes, Respite Services, Social Services Departments, etc, is available. An introduction to the State directory contains a description of community services appropriate to the needs of persons with dementia and suggestions about which services may be more useful as the dementia progresses. ($10.00 per set-hardcopy &diskette)

To order any of these products or additional copies of this final report ($25.00/copy), please send prepayment (check, money order, or requisition **payable to Virginia Commonwealth University**) to:

Caregiver Project
c/o Virginia Center on Aging
Virginia Commonwealth University
P. O. Box 980229
Richmond, VA 23298-0229

OR Call Constance Coogle or Ruth Finley (804) 828-1525 for more information.

Pre-publication dissemination activities included distribution of a four-page marketing flier at the:

1) 15th Annual Meeting of the Southern Gerontological Society - April 22, 1994
2) 12th Annual Meeting and Conference of the Association for Gerontology and Human Development in Historically Black Colleges and Universities - February, 1994
3) Joint Meeting and Conference of the Virginia Coalition on Aging and the Virginia Association on Aging - December 2-3, 1993
4) 49th Boule of Chi Eta Phi Sorority , Inc. - July 13, 1994

From these efforts, project staff assembled a data base of 65 individuals wishing to be notified of the availability of the training manual and 15 who were interested in the State directory of resources. A press release announcing the availability of the training manual was sent to 22 Aging Organizations listed in the Directory of Resources in Dissemination By Design (Karsten & Kasab, 1994). Subsequently, the project produced a brochure to market the products nationally. Approximately 9,000 brochures were mailed to the following organizations/individuals or given out at conferences, meetings, etc.:

* 14 Principal Investigators of AoA-funded projects in the areas of Alzheimer's Disease and minority aging (obtained from a directory of final report abstracts from the National Aging Dissemination Center at the National Association of State Units on Aging).
* Approximately 120 faculty representatives of the Association for Gerontology in Higher Education member schools
* Approximately 800 members of the Southern Gerontological Society
* Approximately 100 state aging contacts identified by the USDA Extension Service
* 200 members of the Southeastern Association of Area Agencies on Aging
* Approximately 2000 individuals receiving "AGE in Action," the newsletter of the Virginia Center on Aging and the Virginia Geriatric Education Center
* 600 individuals identified by the Virginia Department for the Aging
* 205 individuals and organizations affiliated with the Virginia Association of Home Care Professionals
* 42 rural members of the Southwest Virginia Seminar on Aging
* 400 members of the Virginia Health Care Association
* 200 members of the Alabama Gerontological Society
* 50 members of the Mississippi Gerontological Society
* 400 individuals and organizations affiliated with the Florida Department of Elder Affairs
* 260 individuals and organizations affiliated with the Alabama Commission on Aging
* 300 individuals affiliated with the Georgia Office on Aging

Complimentary copies of the training manual have been sent to 57 State Units on Aging along with brochures to be distributed to Area Agencies on Aging and a cover letter asking them to share the manual with the State's Department of Mental Health. Bob Jones at our Regional Office of the Administration on Aging offered to distribute almost 40 training manuals to the other four regional offices (Dallas, Chicago, Kansas City, and Atlanta). Dr. Mary Williams at the Morehouse School of Medicine received 10 complimentary copies and four copies were sent to the officers of the Association for Gerontology and Human Development in HBCUs.

To date a total of 26 complimentary copies of the training manual have been distributed to individuals involved in the project, i.e., contributors to the manual, two Alzheimer's Association Chapters (Greater Richmond & Southside), caregivers featured on cover and inside of manual, photographer, graphic designer, and others who assisted project staff in some substantial way or have offered to assist with dissemination (e.g., Alzheimer's Association Public Policy Office, Alzheimer's Disease Education and Referral Center, National Alzheimer's Association Multicultural Outreach Coordinator, two Alzheimer's Association Chapters involved in multicultural outreach, etc.). As of this time, checks have been processed for 92 recipients of the training manual, 33 copies of the Replication Plan, 16 copies of the National Directory of Resources, and 9 copies of the Virginia State Directory of Resources. Sufficient inventory is on hand for future orders.

Continued dissemination activities planned beyond the project period include:

1) Follow up with Kara Kennedy, Multicultural Outreach Coordination for the National Alzheimer's Association, about announcing the availability of the training manual in the Patient and Family Services newsletter distributed to all Chapter Presidents, Executive Directors, Program Directors and Regional Delegates. The manual will be listed in the Greenfield Library Bibliography and will be used by the National Association in their Chapter development efforts.
2) Presentation of a paper at three professional meetings, i.e., Southern Gerontology Society (April, 1995), American Society on Aging (March, 1995), and the Association for Gerontology and Human Development in Historically Black Colleges and Universities (March, 1995);
3) Follow up with the National Association of Meal Programs for their assistance with obtaining a mailing list for dissemination of the brochure;
4) Arranging to have the manual listed in the compendium of publications compiled by: a) Geriatric Education Centers and 2) the Brookdale Center on Aging;
5) Working with the Virginia Department for the Aging and the Area Agencies on Aging in the targeted region to publicize the availability of the State Directory of Resources and the two regional directories;
6) Display the training manual and distribute brochures at future Annual Meetings of the Virginia Association on Aging and the Virginia Coalition on Aging; and
7) Follow up with the Association for Gerontology and Human Development in Historically Black Colleges and Universities about dissemination of brochures or complimentary copies of training manual.

FINAL REPORT

TABLE OF CONTENTS

Chapter 1: Introduction

Dementia and Caregiving 1
Dementia and Caregiving in African American Communities 2
Dementia and Caregiving in Rural Communities 4
Limited Previous Efforts 5
The Current Project 5
Objectives 6

Chapter 2: Methodology

Objective I: Forming Partnerships 7
Objective II: Developing the Training Package 8
Objective III: Implementing the "Train the Trainer" Model 10
Objective IV: Evaluating the Project and Producing Replication Plan 16

Chapter 3: Findings and Outcomes

Results of Nominal Group Process 18
Formative Evaluation from Regional Needs and Resources Teams 18
Two-Day Training Sessions 19
A Comparison of Two-Day and Abbreviated Training 20
Workshop for Caregivers 21

Chapter 4: Discussion

Introduction 24
Collaboration 24
Outreach 26
Capacity Building 26
Evaluation 28

Bibliography 29
Appendices 33
- Appendix I
  - Suggested Reading List for Trainers
  - Central Virginia Caregiver Directory of Resources
  - Southside Virginia Caregiver Directory of Resources
  - Certificate of Appreciation for Caregiver
- Appendix II
  - Examples of Newspaper Articles about Project/Trainers

Appendix III
  Scheduling Feedback Forms from Trainers
  Suggested Reading Lists for Caregivers
  Project Director's Workshop Evaluation Form

Appendix IV
  Results of Nominal Group Process - Central Virginia
  Results of Nominal Group Process - Southside Virginia
  Regional Needs and Resources Teams Questionnaire

Appendix V
  An Evaluation of First Level Training
    Appendix V-A: Original Pre-Training, Post-Training Questionnaires
      Two-Day Training Evaluation Questionnaire
    Appendix V-B: Revised Pre-Training, Post-Training Questionnaires

Appendix VI
  A Comparison of Full (Two-Day) and Abbreviated (One-Day) Training

Appendix VII
  Calculations for Time Commitment by Trainers

Appendix VIII
  An Evaluation of Second Level Training
    Appendix VIII-A: Original Pre-Workshop, Post-Training Workshop Questionnaires
    Appendix VIII-B: Revised Pre-Workshop, Post-Workshop Questionnaires
    Appendix VIII-C: Workshop Evaluation Questionnaire

CHAPTER 1: Introduction

Dementia And Caregiving

One of the most at-risk groups of the elderly is those with dementia. Dementia is not a disease, but rather a group of symptoms which may accompany certain diseases or conditions. The term "dementia" refers to the loss of intellectual capacity to the point where daily functioning is impaired. Alzheimer's Disease (AD) is the most common form of dementia accounting for 65% of dementia cases (Kaplan & Sadock, 1988). AD affects approximately four million Americans, or 10% of adults age 65 to 75 and 25% of those over age 85 (Evans, Funckenstein, Albert, Scherr, Cook, Chown, Herbert, Hennekens, & Taylor, 1989). The National Alzheimer's Association reports that the prevalence in those age 85 and older may be as high as 47.5%.

Due largely to the efforts of family caregivers, most persons with Alzheimer's are able to remain in the community and avoid premature institutionalization. The most appropriate care setting for Alzheimer's patients is in the home until the late stages of the disease when 24-hour care is required. Despite the fact that AD is considered the most socially disruptive of all ailments and the most taxing on the primary caregiver (Brody, 1989), families continue to cope with the cognitive, behavioral, and emotional decline that accompany AD.

A very recent survey of family caregivers of persons with dementia emphasized the need for more information about case management, and community-based service eligibility and availability (MaloneBeach, Zarit, & Spore, 1992). There is also a documented need among caregivers of demented patients for general information about dementia as well as the availability of home-based services, adult day care, and support group contacts (Coyne, 1991). Recognition of both the societal value of family caregivers and the distress they experience has resulted in the development of a variety of education support programs (Gallagher, Lovett, & Zeiss, 1989).

However, only recently has attention been focused on Alzheimer's family caregivers in African American or rural communities. The Fourth Report of the Advisory Panel on Alzheimer's Disease to the U. S. Congress and the U.S. Department of Health and Human Services calls for "public education and outreach efforts specifically targeted to ethnic elders and their families and communities through the development and dissemination of culturally relevant materials emphasizing both the established facts about [Alzheimer's Disease and Related Disorders] and the efficacy of seeking treatment" (Advisory Panel on Alzheimer's Disease, 1992, p. 50). There is a similar need to train family caregivers of rural elders with dementia, whose informational and service needs may be greater than their urban counterparts. **While some of the inequities have been addressed by federal financing and state initiatives, rural and minority elderly and their family caregivers remain under-served.**

Dementia and Caregiving in African American Communities

Numerous conditions specific to African Americans present challenges in giving care to elders with dementia. There is some suggestion that the prevalence of dementia is higher among elderly Black community residents (Heyman, Fillenbaum, Prosnitz, & Raiford, 1991). This may be due to an increased risk of stroke as a consequence of high blood pressure. African American family caregivers of elders with dementia have a great need for information about Alzheimer's disease, affordable respite services, and counseling to resolve major family conflicts (Segall & Wykle, 1988). Black elders receiving home care services have more limited knowledge and access to services than their White counterparts (Harel, 1986). Rural Black caregivers of Alzheimer's Disease patients are particularly unlikely to seek eldercare information or services (Wood & Parham, 1990). As a consequence of this tendency to under-utilize community service resources (Deimling & Noelker, 1989), African American family caregivers face challenges which typically exceed those of non-minority elder-caregivers. Ethnic and cultural variations may influence family perceptions about the acceptability of seeking help from outside the family (Holmes, Teresi, & Homes, 1983). Although African American families are more likely to rely on informal or familial assistance with health and financial problems (Mindel, Wright, & Starrett, 1986; Ulbrich & Warheit, 1989), this does not negate the need for services or the right to be served.

Barriers

Several barriers affect service utilization among minority elders and their families (Ballard, personal communication, 1993; Henderson, Alexander, & Gutierrez-Mayka, 1989). These include:

1) actual or perceived racial discrimination;
2) a lack of familiarity with services and providers;
3) fear or suspicion of agencies providing services;
4) cultural "sacred cows," which make service use incompatible with beliefs and values of the individual, e.g., "we take care of our own";
5) a lack of service providers trained to be especially sensitive to minority issues; and
6) a lack of minority involvement in service planning and needs assessment.

Impoverished African American families have adopted a number of adaptive behaviors to deal with low income situations that sometimes have persisted for generations. These behaviors make it difficult for them to seek out formal assistance. There is some suggestion that the effective provision of services to minority elders must be planned and executed in new and creative ways. "To accept the fact that the Black elderly experience problems differently or more intensely because of the additional impact of racial discrimination is to suggest perhaps public provision of resources should be handled differently for them" (Rathbone-McCuan & Hashimi, 1982, p. 117).

Successful educational efforts to reach Black and rural caregivers must reinforce the basic family infrastructure by recognizing the desire to remain self-reliant, while simultaneously providing an acceptable mechanism for improving caregivers' knowledge and skills. Given the dynamics of caregiving among Black families with dementia, the challenge is to develop educational interventions that are at once sensitive to and supportive of caregivers' sense of self-reliance, and are responsive to the needs of the at-risk elders for services and information.

Coping Strategies

Studies of cultural differences in coping strategies employed by family caregivers of Alzheimer's patients indicate some culture-specific strengths for African American caregivers. Wood and Parham (1990) reported more frequent use of prayer as a means of coping among Black caregivers in their sample. While White caregivers in this study reported more behavioral coping strategies, such as attendance at Alzheimer's support group meetings, Black caregivers reported more use of a number of internal cognitive strategies for coping. These included reliance on religious belief systems and more frequent reframing of the situation in positive terms. Many of these cognitions (e.g., "I have to get through this. I've been through a lot before; I'll get through this, too.") reflect determination to survive the caregiving experience. Similarly, Segall and Wykle (1988) found that Black caregivers of dementia patients selected two dominant styles of coping in caring for their confused relatives: (1) prayer and faith in God and (2) accommodating oneself to the situation. These types of coping strategies would seem to be adaptive for Alzheimer's caregivers who may be powerless to change the external and objective stressors in the caregiving situations (Wood & Wan, 1993).

Studies comparing caregivers of different racial or ethnic backgrounds have not found significant differences in the amount of strain or burden experienced by Black caregivers (Cantor, 1983; Morycz, 1985; Wood & Parham, 1990). Although ethnic or cultural differences in sources of strain have not been investigated, some special strains and unique strengths may be rooted in the philosophical orientation of African American culture (Wood & Wan, 1993).

African Americans do not use nursing homes at the same rates as non-minorities. Only three percent of Black elders over the age of 65 are institutionalized, in comparison with five percent of White elders. Data from the National Long-Term Care Channeling Demonstration indicated that Blacks have less than half (45%) the odds of Whites of nursing home admission (Greene & Ondrich, 1990). Studies based on other data have estimated that older African Americans are admitted to nursing home at between half and three-quarters of the rate of older Whites (Hing, 1989; Liu & Manton, 1989). Morycz (1985) found, in a small sample (N = 18) of Black caregivers to relatives with Alzheimer's disease, that decisions to institutionalize were predicted most often by conflicts with the patient. In general, however, caregiver strain did not play a significant role in predicting desire to institutionalize (Morycz, 1985). These data may reflect a propensity for Black families to delay admission until their resources are unable to support continued care. When informal resources are exhausted, institutional services may be sought as a resource of last resort (Wood & Wan, 1993).

Dementia and Caregiving in Rural Communities

There is very little information about dementia and caregiving in rural areas. The incidence of dementia in nonmetropolitan areas is probably the same as in metropolitan areas. Methodological differences among incidence/prevalence studies between different geographical areas make it difficult to draw firm conclusions, and no consistent patterns have yet emerged (Brayne & Calloway, 1989; Muir & Brayne, 1992). It is likely that dementia is under-diagnosed in rural areas, however, since specialized diagnostic and evaluative services are extremely limited (Buckwalter, Smith, & Caston, 1993). Anecdotal information suggests that rural physicians are reluctant in some instances to inform family caregivers when Alzheimer's disease is suspected. In the absence of a cure, some physicians paternalistically prefer to protect families from the anguish and communal stigma that such a diagnosis may entail.

Barriers

The problems of limited access, a lack of trained professionals in geriatric mental health, lack of outreach, and inadequate benefits are even more severe and more consequential to isolated rural elders (see Wagenfeld, 1990 for a 10-year review of the literature documenting urban-rural differences in access, availability, staffing, & quality of mental health services). Very often when mental health care is provided, it comes from nurses, social workers, and others without advanced training in the delivery of mental health services (Jones & Parlour, 1985). For example, the Statewide Survey of Older Virginians (McAuley, Arling, Nutty, & Bowling, 1980) found that 23.2% of elders who were treated for mental health problems received these services from a member of the clergy.

Attitudes about Mental Illness

Cultural beliefs and the stigma attached to mental illness may be the most important barriers to the use of mental health services in rural areas. Mental problems are regarded as private family difficulties, and those who turn to scientific medicine may be thought "desperate" (Hill, 1985). Accepting mental health assistance is seen by some as a sign of personal weakness and tantamount to defeat (Smith & Buckwalter, in press). The "fear of stigma is so strong among some of the [rural] elderly that they never reach out for assistance" (Rathbone-McCuan & Hashimi, 1982, p. 102). Many elders fear being labeled as "crazy" and believe they will be abandoned or "locked up" if they accept mental health assistance. They wrongly believe that mental illness is still treated by putting people in state mental hospitals or asylums. For the rural elder who values freedom and independence, institutionalization looms as a "fate worse than death." Their families are afraid that when neighbors and friends find out about their older relatives with mental problems, "they will become the topic of town gossip, the brunt of bad jokes, and will be avoided, shunned, or ostracized" (Buckwalter, Smith, & Caston, 1993, p. 281).

Coping Strategies

There is some very recent data indicating that the opportunity to join Alzheimer's support groups may be equal in rural and urban areas. As many as 85.6% of Area Agencies on Aging (AAAs) which cover exclusively rural Planning and Service Areas offer Alzheimer's support groups (Bane, Rathbone-McCuan, & Galliher, 1994). Unfortunately, these data do not indicate the extent to which this service is accessible or the levels of utilization. In contrast, 97.2% of AAAs which serve mixed Planning and Service Areas offer support groups. Interestingly, a greater number of these rural AAAs (31.8%) directly fund this service either wholly or in part, while only 24.4% of AAAs which cover mixed Planning and Service Areas provide funding for Alzheimer's support groups.

There is very little research comparing rural and urban family caregivers of elders with Alzheimer's disease or dementia. One seminal study, however, examined differences in the coping strategies employed by rural and urban family caregivers (Wood & Parham, 1990). Urban caregivers tended to think of themselves as being in a comparatively better situation than most people, while rural caregivers were less likely to endorse this view. Urban caregivers were more likely to attend Alzheimer's support groups and received more psychosocial support from family and friends.

Limited Previous Efforts

Several recent initiatives funded by the Administration on Aging (AoA) have developed educational materials targeted to minority families caring for loved ones with Alzheimer's (see Aging Magazine, 1992, Numbers 363-364 for a review). Two have targeted African American family caregivers. The Morehouse School of Medicine (Williams, 1992) provided information and training to low-income, inner-city, African American caregivers in Atlanta. The Suncoast Gerontology Center, University of South Florida (Grise, Henderson, & Gutierrez-Mayka, 1989) organized Alzheimer's disease support groups for African American families in Jacksonville. Both projects demonstrated the importance of engaging community leaders and other trusted individuals in the delivery of education and support to these family caregivers. Another previously funded AoA project, The Model Training Project for Family Caregivers of Rural Minority Elderly (Wood, 1985), used a mutual support group context in conjunction with didactic and therapeutic approaches to train family caregivers of Black elders in rural Southside Virginia.

The Current Project: Assisting Family Caregivers of African American and Rural Elders with Dementia: Progressive Training Through Trusted Resources

The current project draws from Wood's rural caregiver project and the more recent initiatives to educate and support African American Alzheimer's caregivers. The current project is a two-pronged, caregiver information and training program which focuses on African American families (in both rural and urban areas) and rural families (both minority and non-minority) who care for elders with dementia.

The current project recognized the enormous challenge of making inroads in responding to the needs of rural and Black caregivers of elders with dementia. So, it has undertaken a strategy of two-step or two-tier intervention in order to maximize the project's impact. In the first step, the project would secure the commitment and involvement of trusted and respected members of the African American and rural communities. These were to include and have included pastors, religious leaders, and other community figures. The project would go to various places to train these "trusted resources," conducting training on the various stages of Alzheimer's disease and dementia, caregiver needs, and locally available resources. Capitalizing on the recognition and trust that these community figures enjoyed, the project in the second step would then help arrange to pair them into training teams which, in turn, would commit to offering workshops for a minimum of ten Black and/or rural family caregivers of elders with dementia. In this way, the project intended to reach 60 or more community leaders who were likely to remain as resources after the project ended, and 300 or more caregivers whose needs for recognition and assistance were complex and historically under-served.

Objectives

The project activities centered around four major objectives, as follows:

Objective I: To form a partnership of the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia, to be called Regional Needs and Resources Teams (RNRTs).

Objective II: To develop a comprehensive, culturally sensitive training package targeted to caregivers of elders with dementia that is organized according to the progression of cognitive, social, and behavioral impairment.

Objective III: To implement and test the "train-the-trainer" model as a mechanism for caregiver education.

Objective IV: To evaluate the project and disseminate findings for replicability beyond the project period and beyond the geographical regions.

CHAPTER 2: Methodology

Objective I: Forming Partnerships

The project formed a partnership of the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia, to be called Regional Needs and Resources Teams (RNRTs). The partnership involved majority and minority institutions of higher education, two local chapters of the Alzheimer's Association, the State unit on aging, area agencies on aging, and other service provider organizations in Central and Southside Virginia. Regional Teams in Central (37 members) and Southside Virginia (24 members) were established and advised project staff concerning the educational needs of caregivers and resources available in the targeted regions. RNRTs were comprised of the most relevant and significant organizations that might address the continuing needs of targeted caregivers. Faculty members at Historically Black Colleges and Universities, representatives from relevant state agencies (e.g., Aging, Health, & Mental Health), local service agencies (e.g., area agencies on aging, adult day care centers), two Alzheimer's Association chapters, and statewide/regional church organizations all participated as project advisors. The inclusion of prominent members of the clergy provided entree to the organization of churches and facilitated the involvement of trusted church leaders who served as trainers and encouraged the participation of family caregivers.

The RNRTs have been an integral part of the project since its inception. They initially guided project staff in identifying the training needs of the family caregivers using a modified nominal group process. The nominal group process allows individuals with widely disparate backgrounds to come to a consensus about a central issue of concern to all. Insights from participants are clarified and consolidated. A priority list is arrived at through a democratic process (voting). Participants "brain-storm" about a particular problem area to generate ideas for clarification and consolidation. In a nominal group process there is no such thing as a "bad" idea. All suggestions are recorded, then participants suggest ways in which the ideas can be connected to each other (consolidated) to form higher-order goals. Ideas which need to be clarified in the process of consolidation are explained by the participant offering the idea. A finalized list of suggestions is arrived at, and participants vote to establish priorities.

Members of the RNRTs who participated in the nominal group process were subsequently mailed a questionnaire and asked to provide feedback about the success of that activity. The questionnaire asked respondents to: (1) rate the extent to which the nominal group process was successful in identifying curriculum content, and (2) offer important training topics not identified as a consequence of the nominal group process. With regard to the first question, participants were asked to respond in terms of a four-point Likert-type scale (0=Could not attend meeting; 1=Not Very Successful; 2=Somewhat Successful; and 3=Very Successful) to a question which read, "How successful was the nominal group process in helping us identify important training topics and information useful to family caregivers?"

RNRT members also advised project staff about the barriers which have traditionally prevented rural and Black caregivers from taking advantage of educational opportunities and ways to engage Black caregivers in the training. Later RNRT members contributed to the writing and editing of the training manual, assuring that the manual was culturally sensitive and literacy appropriate. Some members participated in the training of trainers by serving on community resource panels providing local expertise and discussion of services available to family caregivers. The RNRT membership assisted project staff in the recruitment of appropriate trainers to provide caregiver education. Other members volunteered to serve as Access Resource or Caregiver Contact participants assisting trainers in the recruitment and identification of family caregivers.

Objective II: Developing the Training Package

The training manual, Families Who Care: Assisting African American and Rural Caregivers Dealing with Dementia, is a substantive training manual designed to train family caregivers of persons with dementia, especially those in African American and rural communities. The training manual was field tested with 69 community leaders (members of the clergy, nurses, teachers, social workers, etc.) who, in turn, provided community workshops for over 200 family caregivers in African American and rural communities in Central and Southside Virginia. The manual is organized in two parts. Part I has an Introduction and five (5) chapters designed to educate trainers about dementia, ethnic competence, rural considerations, adult learning theory, and how to conduct workshops:

Part I: Trainer Instruction

* The **Introduction** orients trainers to the manual's purpose and rationale. It provides a brief overview of Alzheimer's Disease and discusses caregiving issues. The Content Preview presents the global structure of the manual in two parts with two purposes. The Introduction also poses a personal challenge to trainers.
* **Chapter 1: Dementia and Caregiving Issues** provides basic information about Alzheimer's Disease and other dementias, with special attention to caregiver issues.
* **Chapter 2: Ethnic Competence for Trainers of African American Caregivers** focuses on African American caregivers with a discussion of how culture and ethnicity impact the aging process.
* **Chapter 3: Special Considerations for Trainers of Rural Caregivers** gives specific information about the differences between elderly populations in rural and urban areas, noting special considerations important to trainers of rural family caregivers.
* **Chapter 4: How Adults Learn** instructs trainers on how adults learn with an overview of adult learning principles and theories.
* **Chapter 5: Recruitment of Caregivers and Conducting Workshops** provides step-by-step instruction on recruiting caregivers, finding a meeting site, and conducting the workshops. Sample publicity flyers, church bulletin inserts, and press releases are provided.

Most chapters include supplementary reading and reference lists for advanced preparation.

Part II contains 19 Caregiver Lesson Plans, organized in modular format. The Caregiver Lesson Plan modules "stand alone" so that trainers can tailor their workshops to fit the particular educational needs of family caregivers. Workshop modules were loosely organized to correspond to the progression of dementia so that caregivers could attend only the workshops that they regarded as personally relevant. Previous studies indicate that caregivers regard their caregiving situations as unique and are willing to attend educational programs only when they felt that their particular needs will be addressed (Manahan, 1992). Promoting specific workshops which correspond to the various stages of dementia is advantageous. When marketing the series, potential participants are informed that they can choose to attend only those workshops which directly pertain to their personal caregiving situation. For example, the first workshop can deal with issues important when symptoms first become apparent, while the second workshop covers problems that arise later on in the illness, and the third workshop focuses on the end stages.

Part II: Caregiver Lesson Plans*

A. The Earlier Stages
  Module 1: An Overview of Dementia and Caregiver Issues (9)**
  Module 2: Caregiver Burden (10)**
  Module 3: Coping with Stress (9)**
  Module 4: Sharing Responsibilities (11)
  Module 5: Legal and Financial Issues (12)**
  Module 6: The Grieving Process (9)

B. The Middle Stages
  Module 7: Managing the Daily Routine (8)**
  Module 8: Safety & Environmental Adaptations (9)
  Module 9: Formal Supports and Resources (13)**
  Module 10: Managing Episodes of Aggressive or Hostile Behavior (10)
  Module 11: Managing Resistive Behavior Associated with ADLs (9)**
  Module 12: Managing Wandering (8)
  Module 13: Communicating with the Patient (9)**
  Module 14: The Caregiver's Spiritual Resources (11)
  Module 15: Compassionate Caregiving (9)
  Module 16: Drug Treatment: Side Effects and Misuse (10)
  Module 17: Alcoholism and Alcohol Abuse: What African-American Family Caregivers Need to Know about the Risks (12)

C. The Late Stages
  Module 18: Maintaining Urinary Continence (12)
  Module 19: 24 Hour Care (11)**

* Numbers in parentheses refer to Grade Level of Readability

** Required or essential module (pre-post knowledge questions developed)

Each module includes a stated goal, rational, educational objectives, detailed mini-lecture, suggested readings and audio-visual reinforcement, experiential learning exercises, and hand-out materials to be distributed. Each mini-lecture has been graded for literacy appropriateness (tenth grade reading level on the average) and edited for cultural sensitivity. Nine key or core modules were chosen and designated as required modules to be included in all workshop series while the other modules were designated as elective to be covered at the trainer's discretion.

Training packages also included evaluation materials, pre-paid envelopes for returning evaluation materials, a suggested reading list, caregiver resource directories listing particular to the targeted localities in Central and Southside Virginia and certificates of completion to be filled out and awarded to caregiver participants. Appendix I includes the suggested reading list for trainers, the Caregiver Resource Directories, and the Certificate of Appreciation.

Objective III: Implementing the "Train the Trainer" Model

Identification and Recruitment of Trainers and Caregivers

Project staff began recruiting trainers at the beginning of the project and continued an active and concerted recruitment effort until the training events were held. A significant portion of the first nine months of the project was dedicated to this activity and a total of 137 qualified, potential trainers were identified. Project staff were convinced that careful development and application of selection criteria would assure a successful workshop experience for the caregivers. The project sought trainers who:

1) have been trusted community leaders who could encourage caregivers to attend the workshops;
2) have had experience as trainers and were familiar with adult learning principles;
3) have had personal experience as caregivers or an understanding of caregivers' educational needs;
4) have been active in the aging network and knowledgeable of aging issues, Alzheimer's disease, or dementia; and
5) have had experience with ethnic minority populations or specific interests in rural aging concerns.

The involvement of religious leaders in the Black community was deemed an essential feature of the project's outreach efforts. The efficacy of using the organizational structure of churches to provide services to Black elderly has been advocated by Hatch (1991) and the cooperation of Black religious leaders in the community facilitated the effort to recruit Black family caregivers of dementia patients. The project worked with the Baptist General Convention of Virginia (a consortium of regional Associations of Black churches across the state), the Baptist General Association of Virginia (a parallel organization of majority Baptist churches), and the Council of Churches (a statewide ecumenical organization). Face-to-face meetings with Association leaders led to their involvement in the RNRTs, opportunities for speaking engagements during Association meetings, and ultimately, the recruitment of Black ministers and other church leaders as trainers for the project. The churches served as amenable sites for caregiver workshops, and in some cases the project's activities were assimilated into ongoing health-related ministries that churches had already initiated.

The project initiated numerous presentations with professional groups (such as the Black Nurses Association), and other meetings (such as an Area Agency on Aging Resource Coordinator's meeting and a regional caregiver advocacy group). Essentially, the project staff took advantage of every opportunity to inform others in the community of the project's intentions and the on-going search for appropriate trainers and caregivers.

In order to take advantage of extant expertise, the project staff contacted and consulted with key personnel conducting similar projects elsewhere across the nation about outreach efforts that had proven successful (see Replication Plan for list of consultants). A variety of flyers were developed, refined, and widely-distributed. In time, a large data base of pastors was developed and numerous mailings to African American and small rural churches culminated in the development of inserts which could be placed in church bulletins. Thousands of these inserts were duplicated and distributed.

Although some media efforts were undertaken, these were generally less effective than the networking approach. A significant mass appeal on a noon-time news show was singularly unproductive. Announcements placed in local rural newspapers were of some use in "spreading the word" about up-coming workshops, as were informative articles requesting the cooperation of interested persons in newsletters and other publications distributed to personnel in the aging and social services networks. See Dissemination Synopsis in Project Briefs for complete list of print media pertaining to project. Appendix II contains examples of newspaper articles about the project or its trainers.

In the end, it was through word-of-mouth advertising and the personal urging by trusted resources that recruitment efforts succeeded. Caregivers had to be convinced that their attendance at the workshops would be worthwhile before they would make the substantial effort to arrange for respite and arrange their busy schedules in order to attend the workshops. When trainers were already known by caregivers, recruitment was markedly facilitated. In other cases, caregivers needed to be persuaded that the workshops would be personally beneficial before they would commit to attend.

The inclusion of specific grant funding to support caregivers in their efforts to attend the workshops eliminated two of the most obvious barriers to participation -- lack of respite and transportation. Grant funds were used to reimburse caregivers for expenses associated with respite care and transportation. Since workshops were to be held in the caregivers' communities, extensive travel was not anticipated. If caregivers didn't have their own transportation or had trouble driving at night, transportation could be arranged. Trainers were advised to organize carpools, with the carpool drivers (who in some cases would be the trainers themselves) being reimbursed for mileage. Trainers were advised that funds were limited and that project staff wanted to be sure that they were well spent by reserving their use only for caregivers who could not attend the workshops otherwise. The use of adult day care centers as workshop sites was encouraged, since caregivers could bring their care recipients with them and become familiar with this respite option.

Grant funds were also set aside to support trainers in their efforts to conduct the workshops. Trainers were encouraged to maintain records and keep receipts associated with any out-of-pocket expenses they might incur. Since the use of refreshments and caregiver hand-outs was strongly suggested, trainers were assured that reimbursement would be provided by the project.

Training of Trainers

As a condition of participation in the training, potential trainers were asked to commit to form two-person teams and train a minimum of ten caregivers per team. The formation of trainer teams allowed for the presentation of multiple viewpoints and the combination of different abilities. The project team posited that the ideal training team would include one individual who knew caregivers and could encourage their participation, while the other member of the team would have training abilities and expertise related to the training content.

Training participants were asked to attend two-full days of training in order to partially prepare for conducting their caregiver workshops. In order to assure maximum attendance at training sites, potential trainers were given the option of attending four separate training sessions held in various locations within the targeted territory. Two-day training sessions were scheduled at four different sites and trainers could select to attend whichever sites and dates were most conducive to their schedules. In order to accommodate trainers who could not take two full days from work to attend training, one of the two training days was scheduled on a holiday (Veteran's Day).

Upon arrival trainers received the training package (training manual, evaluation materials, pre-paid envelopes for returning evaluation materials, a suggested reading list, caregiver resource directories particular to the targeted localities in Central and Southside Virginia, and Certificates of Appreciation to be filled out and awarded to caregiver participants). Additional training materials included a variety of pamphlets and brochures from national and local service agencies concerned with caregiving, Alzheimer's Disease, minority health, and other pertinent topics.

Presenters with expertise in each of the major training content areas were recruited to conduct the two-day training sessions. Since the success of the project rests largely upon the quality of the training provided to and by these participants, members of the local Alzheimer's Association were recruited to supplement the expertise provided by the project staff. In addition, local community resource panels were assembled to inform trainers of the variety of services available in their area that would be beneficial to their caregiver participants. Training content included:

1) a review of the project's purpose and rationale;
2) an overview of Alzheimer's disease and dementia;
3) sensitivity training covering relevant caregiving issues;
4) a demonstration of adult learning principles;
5) specific instruction on how to identify and recruit caregivers, find a training site, conduct the workshops, and collect evaluation information;
6) some precautionary notes about encounters with instances of unintentional abuse or benign neglect;
7) special considerations for trainers of rural caregivers;
8) presentations by representatives from relevant service organizations; and
9) developing ethnic competence for cross-cultural training.

The two-day training session concluded with a role-play, demonstrating how an actual workshop might be conducted. The use of community resource panels was an especially useful training tool. In addition to individual presentations outlining the services offered by the representative agencies, the moderator chose a case study which typified a dementia caregiving family for the panelists to discuss. Panel members explained how they would approach the case and what assistance they could offer. This activity was quite instructive for trainers who are expected to function as advocates for caregivers, facilitating their entry into the service system and/or arranging for respite so that they can attend workshops when needed.

Project co-directors arranged to have one of the training events video-taped. This material was subsequently edited and became available for potential trainers who could not attend any of the events but had access to caregivers and could pair with someone who was trained.

Trainers evaluated their experience at the end of each training day. Gains in knowledge were documented through the use of pre-training and post-training tests which sampled training content through multiple choice and true/false items. Like the evaluation questionnaires, knowledge tests were administered at the beginning and end of each training day since some participants received their training at different sites in order to accommodate their schedules. This also necessitated the use of two different knowledge tests (with each test sampling training content for that day), although the format for the evaluation questionnaire could remain constant regardless of training day.

An abbreviated training day was planned to accommodate training participants who were either identified after the two-day training sessions were completed or who could not attend the sessions scheduled. It was reasoned that those already knowledgeable about caregiving, dementia, and the aging network could proficiently conduct the workshops without the benefit of additional training in those areas. Alternatively, those who needed the more in-depth training could gain it through viewing the videotape made of the training event and careful study of the training manual. Ideally, abbreviated training participants were those who had some background in aging, Alzheimer's Disease, or caregiving since the overview of dementia and caregiving issues were specifically omitted from the abbreviated agenda. Those who felt the need for extended training in these areas, in addition to the information provided in the training manual, were sent supplementary videos subsequent to the training. The panel of representatives from community services agencies was also omitted from the abbreviated training session. It was anticipated that the caregiver resource directories prepared for two-day training participants would suffice. Trainers were also urged to carefully study the Caregiver Lesson Plan on Using Formal Supports and Resources and investigate the services available prior to the conduct of caregiver workshops. In addition, materials (brochures, flyers, etc.) provided by members of community resource panels were distributed to abbreviated training participants.

Training content included:

1) a review of the project's purpose and rationale;
2) developing ethnic competence for cross-cultural training;
3) special considerations for trainers of rural caregivers;
4) sensitivity training on building trust and dealing with instances of unintentional abuse or benign neglect;
5) a demonstration of adult learning principles; and
6) specific instruction on how to identify and recruit caregivers, find a training site, conduct the workshops, and collect evaluation information;

The abbreviated training session concluded with a demonstration of how an actual workshop might be conducted.

Knowledge gains were measured with an abbreviated questionnaire sampling the training content. Questions were drawn from the knowledge tests used in the two-day training session. The abbreviated training was evaluated using the same instrument used for the two-day training which included items related to the overall effectiveness and utility of the information provided. Specifically participants were asked to evaluate the training experience in terms of the extent to which the training was personally and professionally applicable and useful. Participants were also asked to rate the general effectiveness of the training content and presenters, and the quality of the program materials. They were given the opportunity to provide comments through the inclusion of open-ended questions concerning the most and least helpful aspects of the training, and to indicate any relevant issues not included in the training.

Training of Caregivers

Once first level training was completed, project staff began monitoring workshops, assisting trainers with recruiting caregivers (producing personalized flyers, church bulletin inserts, etc.), and providing other technical assistance as needed. Several techniques were employed as project staff began an independent effort to identify and recruit caregivers to participate in workshops. In addition to articles placed in newsletters and referrals obtained from members of the RNRTs and Access Resource (or Caregiver Contact) persons, project staff sent recruitment information to 242 African American caregiving employees of VCU. Contact information about numerous African American and rural pastors was passed on to trainers as leads to be pursued. In order for staff to track workshops, trainers were asked to complete Scheduling Feedback

Forms (see Appendix III). The feedback forms were to provide staff with the dates, sites, etc., of their proposed, ongoing, or completed workshops. By monitoring their progress, staff could refer caregivers to groups not yet begun or those in-progress. Several different communications to trainers were continued throughout the time workshops were conducted. Some of the correspondence included additional information thought to be helpful as workshops proceeded. For example, two sets of reading lists were created, duplicated, and mailed to trainers to pass on to their caregiver participants (see Appendix III). Other correspondence included mildly worded reminders to trainers whose workshops had yet to be scheduled. When it appeared that trainers were not intending to follow through on their commitment to the project, a more strongly worded reminder was sent.

For purposes of monitoring workshop sessions, the project co-directors completed evaluation forms (see Appendix III). Project co-directors rated workshops with respect to various programmatic aspects, interpersonal aspects, and the teaching options employed. Open-ended questions asked about the best and worst aspects of each session.

Data collection completed by trainers included pre-workshop, post-workshop questionnaires corresponding to each of the nine essential or required modules. Knowledge test items were drawn from the mini-lecture content for each of the nine essential or required Modules or Caregiver Lesson Plans. Both multiple choice and true-false items were included. Since most trainers covered all of the essential modules, nine separate pre-workshop and nine post-workshop tests were distributed. The post-workshop tests were identical to the pre-workshop tests, except for the designation of "Pre-Test" or "Post-Test," and the color of the paper used. Using two different colors made it easier to tell at a glance that all participants were working on the pre-workshop tests prior to the beginning of the mini-lecture and on the post-workshop tests after the conclusion of the mini-lecture.

To demonstrate knowledge gains, pre-workshop and post-workshop questionnaires were scored by assigning a "1" for correct answers and "0" for incorrect answers. If trainers failed to obtain tests for a particular module, or if a caregiver did not answer the items, items were scored as missing. Total knowledge scores were computed by summing across the items contained in each of the nine modules, so that the maximum score possible was "59." The minimum possible was 1. If participants did not answer any items, the total knowledge score was missing. Percentage scores were calculated by dividing the total knowledge score by the number of items answered.

At the conclusion of each workshop trainers were asked to distribute a Workshop Evaluation Questionnaire. Caregivers were asked to use a 1-5 Likert-type scale (with 1 representing "not at all" and 5 representing "extremely") to indicate the overall effectiveness of the trainers and the extent to which they felt the workshop experience was worthwhile. Specifically the Workshop Evaluation Questionnaire asked attendees to give some basic demographic data (i.e., gender, race, place of residence) and indicate the extent to which: 1) the material covered in the workshop was relevant to their particular problems and concerns, 2) attending this workshop made them more aware of help available in the community, 3) they were more likely to use community resources as a consequence of attending the workshop, 4) they gained a better understanding of their care recipients, 5) they gained better understanding of their own feelings about their care recipients, 6) they gained a better understanding of how they can help their care recipients live happier lives, 7) they learned to be better caregivers, 8) the material covered in the workshop was useful in general, and 9) the trainer effectively communicated the workshop content.

Objective IV: Evaluate Project and Produce Replication Plan

The evaluation of the project included formative and summative components as described in the preceding sections. Dissemination activities have been and will be extensive. These are explicated in the Dissemination Synopsis of the Project Briefs.

The Replication Plan for the project, "Assisting Caregivers of Black and Rural Elders with Dementia: Progressive Training Through Trusted Resources," is based upon the Integrated Model for Collaborative Planning and Services to Older Adults with Developmental Disabilities(AoA grant #90AM0680/01) directed by Edward F. Ansello, Ph.D and awarded to the Virginia Department for the Aging. The Integrated Model is a broad, tested process strategy that is relevant for addressing the needs of people who live in the community rather than in institutional settings. As initially conceptualized the Integrated Model has three components: 1) collaboration, 2) outreach, and 3) capacity-building. The Integrated Model Plus (IMP) adds a fourth component, Evaluation. All four components should be incorporated into any replication of this project. A brief discussion of these four outcomes provides a rationale for replicating the project.

Collaboration. One of the main objectives of the project was to form a partnership of the most relevant and significant organizations that might address the continuing needs of Black and rural caregivers of elders with dementia. These partners served a variety of functions for the project, from guiding the content of the training manual to recruitment of trainers and caregiver participants. Some partners served as first level trainers for the project, providing information about community resources and services available to caregivers, while others conducted caregiver workshops. In the process, agency representatives became better acquainted with others in the caregiving service network and begin to establish or further linkages for future resource sharing, referral, and collaboration.

Outreach. The need for outreach to rural and African American caregivers is well-documented in the manual's Chapters. The attendant barriers to service utilization among these two special populations, important considerations to any outreach effort, were addressed as the project sought to increase the likelihood that caregivers would access formal supports. Trainers were trained to function as advocates, in a sense, directing and guiding caregivers to those in their communities who could offer assistance. The outreach component of the project was further challenged by the colloquial stigma attached to dementia and Alzheimer's Disease. Yet, the project succeeded in identifying caregivers previously unknown to the local Alzheimer's Association Chapters and providing the foundation for the development of support groups in unserved communities.

Capacity-building. Another major objective of the project was to implement and test the "train-the-trainer" model as a mechanism for caregiver education. In accomplishing this objective the project directly developed the capacities of trusted community leaders who served as trainers of caregivers, indirectly improved the capacities of caregivers through the conduct of workshops, and subsequently increased the ability of elders with dementia to remain, as appropriate, in their communities and avoid premature institutionalization. The train-the-trainer model allowed for the expertise imparted to endure beyond the scope of the project with those in the community who were trained to conduct workshops, and empowered to do so via the training manual materials.

Evaluation. Evaluation is a significant component of the IMP. Formative evaluation regarding the utility of nominal group process of consensus building for determining African American and rural caregivers' educational needs, and the composition of Regional Needs and Resource Teams is essential. Since all project activities (e.g., recruitment of trainers and caregivers, first and second level training) stem from successful collaboration, formative evaluation provides an effective method of establishing relevant training curricula and assuring that all appropriate partners are involved. Summative evaluation of the first level training (i.e., the training of trainers) provides project staff with an indication of how well the training content was understood. The results of pre-training and post-training knowledge tests may be used to determine where further training or additional information is needed. The results of participants' evaluations of one training session (i.e., applicability and utility of content, effectiveness of presenters, etc.) can be used to improve subsequent sessions. Summative evaluation of the second level of training (i.e., training of caregivers) provides tangible proof that workshops have been successful, that caregivers have learned the workshop content, and that they have benefitted from their participation. By reviewing the results of evaluation questionnaires, trainers of caregivers can easily revise the structure of workshops (e.g., include more video material, spend additional time on certain content areas, or adjust their presentational style). Note: As an alternative to pre-workshop and post-workshop testing, trainers may choose to use the knowledge questionnaire as a didactic aid to reinforce key points by administering the test only at the end of the lecture, and then reviewing the correct answers before the group.

Those who replicate this project through the components of the Integrated Model Plus will not only achieve these stated outcomes, but will also learn much about establishing linkages, networking in African American and rural communities, and developing community expertise to strengthen caregiving families.

CHAPTER 3: FINDINGS AND OUTCOMES

Results of Nominal Group Process

Through a modified nominal group process, five general content areas were identified by the Central Virginia RNRT. Ranked in descending order of importance to family caregivers, these topics were: 1) Emotional and Psychological Consequences of Caregiving, 2) Caregiver Supports, 3) Basic Clinical Information, 4) Safety, and 5) Legal/Financial Issues. The Southside RNRT identified seven content areas ranked in descending order of importance: 1) Disease & Treatment, 2) Patient Behaviors & Interventions, 3) Impact on Caregivers & Family, 4) Caregiver Interventions, 5) Resources, 6) Legal/Financial/Patient Competency, and 7) Placement Options/Continuum of Care. Appendix IV contains the results of the nominal group processes conducted for each of the RNRTs with specific topics included under the broad headings.

Formative Evaluation from Regional Needs and Resources Teams

Initially the project received feedback from the Regional Teams regarding the extent to which the nominal group process was successful in identifying curriculum content (see Appendix IV for copy of survey). Of the respondents who were members of the Southside RNRT and participated in the nominal group process (n=14), all but one respondent rated the process as "Very Successful." That one respondent rated the process as "Somewhat Successful." Of the Central RNRT respondents who participated in the nominal group process (n=14), all but two respondents rated the process as "Very Successful." Those two respondents rated the process as "Somewhat Successful." RNRT members received the results of the nominal group process summarizing the ranked topic categories and the suggested ideas which were included within each category. They were asked if "there are any other important training topics or information useful to family caregivers, not mentioned on the enclosed list of results, that should be included in the training curriculum?" Most respondents indicated that the nominal group process had resulted in a very comprehensive list of topics, and they could not think of any omissions. The few suggestions offered included: 1) concrete "how to" information on starting a support group, 2) how caregivers can be supportive of each other through sharing experiences, 3) the spiritual consequences of caregiving and the supports available through the church, 4) dealing with anger and guilt, 5) resources for caregivers without family members or distant family members (i.e., surrogate caregivers, weekend respite, etc.), and 6) the grief process (i.e., stages and relevance while the patient is still "alive" and after death.

In addition to assessing the nominal group process, the questionnaire asked respondents whether they would be interested in being a trainer for the project, help encourage caregiver participation, develop a training module, or edit the training manual. RNRT members were also asked to refer us to others who would be interested in assisting us with these activities. A total of 61 members were surveyed and 34 questionnaires were returned, yielding a 55.7% response rate. A total of 25 members returned questionnaires following the first mailing, yielding a response rate of 41%. The second mailing to 36 RNRT members who had not responded resulted in nine additional surveys, yielding a 25% response rate for the follow-up.

Thirteen of the 34 respondents (38.2%) indicated on the survey that they would be willing to be trainers for the project, and 14 (41.2%) said that they knew others who would be interested in being a trainer. About two-thirds (67.7%) knew of or had access to minority or rural caregivers (n=23), and almost as many (61.8%) knew of others who had access (n=21). Seven respondents (20.6%) were willing to write a module for the training manual, and all but five (85.3%) agreed to review or edit the training curricula developed to insure that it was comprehensive, culturally sensitive, and literacy appropriate. All referrals were pursued by phone and a simplified summary of the grant project was sent to those who indicated that they had an interest in being a trainer and/or encouraging caregiver participation.

Two-Day Training Sessions

The first level training was evaluated in terms of the effect of education and training on the knowledge levels of trainers, and the overall effectiveness and utility of the information provided. On each training day, participants were asked to complete pre-training and post-training knowledge tests, and to evaluate the training experience in terms of the extent to which the training was personally and professionally applicable and useful. Participants were also asked to rate the general effectiveness of the training content and presenters, and the quality of the program material. They were given the opportunity to provide comments through the inclusion of open-ended questions concerning the most and least helpful aspects of the training, and to indicate any relevant issues not included in the training.

The training evaluation instrument, and the Pre-Training and Post-Training knowledge tests for each of the two first level training days are included in Appendix V-A. Appendix V contains a detailed interim report of the results of Level I training (i.e., the training of trainers). Revised pre-training and post-training evaluation instruments are included in Appendix V-B. A brief summary of the results of data analyses performed on the responses received follows.

Trainers were predominantly African American and disproportionately female. The majority worked or practiced in a rural area. They tended to be well-educated, with almost half possessing advanced degrees. Almost one-quarter were social workers, and more than one-quarter were nurses. The training was well-received, with high marks in all areas of evaluation.

Statistically significant gains in knowledge were demonstrated for both training days. An examination of knowledge gains by item indicated that participants performed better on the first training day than they did on the second training day. This difference was attributed to a greater reliance on guest lecturers on the second day of training. Item analyses revealed that only two of the items on the first-day knowledge test, and four of the items on the second-day knowledge test, were judged to have little discriminative ability. Internal reliabilities were acceptable, given the abbreviated length of the knowledge tests and the limited sample sizes employed.

Site comparisons of knowledge gains achieved indicated that the most remote, rural site performed least well. Participants at the urban site performed better on the second training day than trainers at the other sites. In general, rural participants failed to provide correct answers to about one-third of the post-training test items, while trainers at the urban and mixed sites scored correctly on three-quarters of the knowledge test items.

An examination of other comparisons of trainers resulting in statistically significant knowledge gain differences revealed that: 1) non-minority participants scored better than African American trainers, 2) trainers with four-year degrees out-performed those without degrees, and 3) urban practitioners showed greater knowledge gains than rural practitioners.

Several differences between trainers were noted with respect to their evaluation of the training. In general: 1) trainers at the rural sites provided higher ratings than those at the urban or mixed training sites, 2) African American trainees valued the training more highly than Caucasians, 3) participants with Bachelor degrees regarded the training content as more effective than those with advanced degrees or those without four-year degrees, and 4) nurses thought the training materials were of higher quality than either social workers or those in other disciplines.

A Comparison of Two-Day and Abbreviated Training Sessions

The training evaluation instrument, and the Pre-Training and Post-Training knowledge tests for the abbreviated training day are included in Appendix VI. Appendix VI also contains a detailed summary of the evaluation responses provided by participants and a comparison of full (two-day) and abbreviated (one-day) results. A synopsis of that report follows.

Abbreviated training participants were racially mixed, predominantly rural, mostly female, and highly educated. In these respects, they are similar to the demographic profile of two-day trainers (see "An Evaluation of First Level Training," Appendix V). The training was well received with high marks in all areas of evaluation. A statistically significant overall gain in knowledge was demonstrated. An examination of knowledge gains by item, however, failed to reveal significant differences in response to pre-training and post-training items with respect to all but one item. This was attributed to the small sample size and a ceiling effect resulting from an intentional selection bias. Abbreviated training participants tended to differ from those who attended more extensive training with respect to their evaluations of the program's usefulness and the overall effectiveness of the speakers. With such a small sample participating in the abbreviated training, it is difficult to attribute the differences to format alone since other factors may have contributed. For example, abbreviated trainers may have been especially grateful that project staff would make special arrangements to accommodate their inability to attend the more extensive training. This "halo effect" may in part account for the higher evaluation marks obtained from abbreviated training participants. Differences in overall knowledge gains between the two groups could not be directly ascertained since the knowledge tests employed were not equivalent. A comparison in terms of the 16 shared knowledge test items included on the instruments used, however, indicated a statistically significant difference in terms of only one item. Group differences with respect to one other item approached significance. Again it is difficult to draw any firm conclusions due to the limited sample size, but an examination of least square means indicated that abbreviated trainers may have learned more than two-day participants on two additional items. Yet, the adjusted post-training scores of two-day training participants were substantially higher on two of the knowledge test items. There was no clear trend, then, leading to the conclusion that abbreviated training was superior to the more extended training format. Because abbreviated training participants were a biased sample (i.e., they were either self-selected or hand-picked by the project staff due to their considerable knowledge base in the areas of Alzheimer's Disease and caregiving), no true comparison of format is possible. A more rigorous comparison with participants randomly assigned to training formats is the only way to obtain a definitive conclusion regarding the advantages or disadvantages inherent to each of the training experiences provided. The comparison reported here was an attempt to obtain a rough estimate, given the constraints mentioned. Unfortunately, results were not clear enough to warrant even an educated guess.

Workshops for Caregivers

Of the 69 trainers initially trained, 47 trainers proceeded to complete 19 separate workshops to educate at least 208 family caregivers. They invested a total of 392.5 hours (averaging 8.35 hours per trainer) in direct contact with family caregivers. In total trainers contributed 1,341.5 person-contact hours to the project, in addition to the effort required to recruit participants, organize and plan the workshops, and prepare Lesson Plans. The calculations for these results are given in Appendix VII.

An examination of the project director's evaluations of monitored workshops indicates that sessions were outstanding or satisfactory with regard to most of the programmatic and interpersonal aspects rated. The only area where trainers seemed to be lacking was with regard to the administration of evaluation questionnaires. Yet, even this process was efficiently and effectively handled in some cases and involved minor technical adjustments in other cases. When the workshops monitored were the first sessions conducted, where the rather lengthy caregiver survey was administered, the project co-directors were satisfied that, in general, the evaluation process was not too cumbersome. Although there was considerable variation among trainers in their teaching style and techniques employed, it was apparent that trainers had spent some time reviewing the introductory Chapters of the training manual and had incorporated that awareness in their instruction. They had become completely familiar with the supportive service agencies in their communities as a consequence of their training and freely translated their knowledge to the caregivers who could take advantage of the help available to them.

The second level training (i.e., the training of caregivers) was evaluated in terms of the effect of workshop participation on the knowledge levels of caregivers, and the overall effectiveness and utility of the information provided. For each of the nine required or essential modules, workshop participants were asked to complete pre-training and post-training knowledge tests. At the end of each workshop they were asked to evaluate the workshop experience in terms of the extent to which: 1) the material covered in the workshop was relevant to their particular problems and concerns, 2) attending this workshop made them more aware of help available in the community, 3) they were more likely to use community resources as a consequence of attending the workshop, 4) they gained a better understanding of their care recipients, 5) they gained better understanding of their own feelings about their care recipients,

6) they gained a better understanding of how they can help their care recipients live happier lives, 7) they learned to be better caregivers, 8) the material covered in the workshop was useful in general, and 9) the trainer effectively communicated the workshop content. They were also given the opportunity to provide comments through the inclusion of open-ended questions concerning the most and least helpful aspects of the workshop.

The workshop evaluation instrument, and the Pre-Workshop and Post-Workshop knowledge tests for each of the nine required or essential modules are included in Appendix VIII. Appendix VIII also contains a detailed interim report of the results of Level II training (i.e., the training of trainers). Revised pre-training and post-training evaluation instruments are also included. A brief summary of the results of data analyses performed on the responses received follows.

Of the 165 caregivers who completed workshop evaluation forms, almost three-quarters of respondents were African Americans and the majority (about 85%) were women. Almost three-quarters lived in rural areas.

The results of the Workshop Evaluation Questionnaires indicate that the workshop content was relevant to the personal problems and concerns of caregivers. Caregivers learned a great deal about AD, caregiving, and other information included in the mini-lectures for each of the Caregiver Lesson Plans. They became more aware of community resources available to help them with their caregiving responsibilities and, as a consequence of attending the workshops, they are more likely to access the available help.

With regard to the most helpful aspect of the workshops, many caregivers indicated that everything about the workshop was helpful. The most popular other responses included:

1) Learning the importance of caregivers taking care of themselves in order to take better care of the care recipient;
2) Learning from others with similar experiences;
3) Handouts distributed by trainers;
4) Gaining an in-depth understanding of the disease; and
5) Group support.

Other responses mentioned by more than a few participants included the trainers, learning about legal issues, coping with stress, and Cognex. With regard to the least helpful aspect of the workshops, many caregivers indicated that all aspects were helpful. The most popular other responses included the amount of paperwork, i.e., completing evaluation questionnaires, and the lack of sufficient time allotted to cover a particular topic.

To demonstrate knowledge gains, pre-workshop and post-workshop questionnaires were scored by assigning a "1" for correct answers and "0" for incorrect answers. If trainers failed to obtain tests for a particular module, or if a caregiver did not answer the items, items were scored as missing. Total knowledge scores were computed by summing across the items contained in each of the nine modules, so that the maximum score possible was "59." The minimum possible was 1. If participants did not answer any items, the total knowledge score was missing. Percentage scores were calculated by dividing the total knowledge score by the number of items answered.

Prior to the mini-lecture, the average percent score was 61.47% (S.D. = 12.30). That is, participants answered 21.55 of the 59 questions correctly on the average. After training, average percent scores increased to 74.03% (S.D. = 14.28) or 26.30 items correct on the average. This constituted **a statistically significant gain in knowledge** (t = 13.54; p= .0001).

Statistically significant knowledge gains were demonstrated for each content area. The greatest gains were found for Module 3: Coping with Stress, while the least gains were noted for Module 2: Caregiver Burden. Although the pre-workshop scores for these two modules were substantially lower than for the other nine essential content areas, participants appeared to learn a great deal about how to cope with stress, while their understanding of caregiver burden remained incomplete.

Out of the 59 items employed in caregiver knowledge tests, the majority (34 or 57.63%) were indicative of statistically significant increases in knowledge at either the .01 or .025 alpha level. A total of 20 items were dropped when revising the knowledge tests because they were either too easy or too difficult. The remaining 39 items were included in the revised tests (Appendix VIII-B) because they showed ideal discriminative ability, or because they showed linear or partially linear trends.

CHAPTER 4: Discussion

Introduction

The project, its products, and its findings have implications which extend beyond the achievement of stated objectives. As a mechanism of **collaboration**, the project furthered levels of cooperation and promoted resource sharing among the many partners who served on Regional Needs and Resource Teams (RNRTs). The **outreach** strategies developed and employed serve as guidelines for others interested in breaching the barriers to service provision for minority and rural elders and their families. Just as the project directors consulted with many of the researchers, practitioners, and scholars who continue to pursue multicultural and rural outreach, the current project contributes now, to the "ground swell" of inclusionary policy and practices. In some sense, the **collaborative** and **outreach** activities of the project served the fundamental intent to **build the capacities** of trusted community leaders, who could then translate their knowledge and sense of empowerment to family caregivers. By insisting that the training manual content be culturally sensitive and literacy appropriate the project has developed a much-needed tool for educating African American and rural families in an arena that has only recently begun to have such materials available. Due to the exhaustive analyses of Levels I and II training, **evaluation** data support the effectiveness of the train-the-trainer model as a suitable mechanism for caregiver education. With regard to these four components (i.e., **collaboration, outreach, capacity building, and evaluation**) the project has certain relevance to others who labor in the field of aging.

Collaboration

The project has succeeded in joining together majority and minority institutions of higher education, two Alzheimer's Chapters, State and local service agencies, and prominent members of the religious community. By promoting collaboration among members of the Regional Needs and Resources Teams, project staff introduced potential partners who had not previously thought about working together and united them under the rubric, "Assisting Black and Rural Caregivers of Elders with Dementia." As they realized their shared intention to address the continuing needs of targeted caregivers, RNRT partners began to become aware of the advantages of joining forces and sharing resources. To wit, the following partners were represented on the RNRTs:

Majority and Minority Institutions of Higher Education
Virginia Commonwealth University
Saint Paul's College
John Tyler Community College
Virginia State U. Wellness Center
Virginia Union University
Southside VA Community College

State/Regional Health/Medical Organizations
Va. Primary Care Association, Inc.
Area Health Education Centers Program
McGuire Veterans Affairs Medical Center
Virginia Health Care Association

State Departments/Boards/Advocacy Groups
Office of Geriatric Services, DMHMRSAS
Va. Dept. for the Aging
Va. Dept. of Social Services
Va. Dept. of Health
Governor's Advisory Board on Aging

Local Departments
Surry County Health Department
Petersburg Health Department
City of Richmond Community Service Board
Southside Community Services Board

Regional/Local Service Provider Agencies
Meals on Wheels
Volunteer Visitor Program
Richmond Redevelopment and Housing Authority
IVNA Home Health Care

Day Care Centers/Nursing Homes/Hospitals
Stuart Circle Center
Richmond Community Senior Center
Woodview Nursing Home
Heritage Hall
Piedmont Geriatric Hospital
Community Memorial Healthcenter

Area Agencies on Aging
Crater District Area Agency on Aging
Northern Neck-Middle Peninsula AAA
Rappahannock AAA, Inc.
Capital Area Agency on Aging
Lake Country Area Agency on Aging
Piedmont Senior Resources

State/Regional & Local Religious Community Leaders
Zion Baptist Church
Interfaith Coalition for Older Virginians
Va. Institute of Pastoral Care
No Greater Love Project
Star of the East Association
Shilo Baptist Association
Baptist General Association

Alzheimer's Association Chapters
Greater Richmond
Southside Virginia

Although there has always been good communication and collaboration between the State Department for the Aging and aging-related offices of the other State Departments, projects such as the current one provide an opportunity for furthering that strong relationship. With the proposed restructuring of long-term care services in Virginia, the various State Departments may be jointly redefining and solidifying their resource sharing and networking activities to more effectively serve elders with dementia and their caregiving families in Virginia. It is anticipated that the training materials developed for this project will be more widely disseminated among and utilized by aging personnel in these State Departments. For example, a training specialist in the Division of Licensing at the State Department of Social Services has used several of the Caregiver Lesson Plans in training owners of Homes for Adults. The utility of the training manual has only begun to be discovered.

Indeed, as the project continued, the collaborative importance of contributions by multiple members of the RNRTs became apparent. For example, a Resource Coordinator from one of the Area Agencies on Aging prompted a Case Manager at that agency to contact the Alzheimer's Association of Greater Richmond Chapter about securing a Respite "Scholarship" for an African American caregiver attending workshops conducted by Instructional Visiting Nurses Association. The caregiver had taken advantage of the respite support available through the project and provided by Catholic Family Charities, Inc. At the workshop she learned of the advantages of respite, and the kinds of respite options that might be available to her. Empowered by her workshop experience, she continues to explore and access respite.

Outreach

The proliferation of culturally sensitive educational materials for Alzheimer's caregivers is remarkable given the preceding dearth of available resources. Some excellent materials are being developed at the grassroots level by local Alzheimer's Association Chapters. The Director of Multicultural Outreach of the Patient and Family Services Committee at the National Alzheimer's Association office has recently developed a handbook for Chapters interested in doing multicultural outreach. At the present time the manual is only available to Chapters, but the Program Director of the Greater Richmond Chapter will be using that manual in conjunction with the one created for this project to diversify the composition of the Board, the membership, the support groups, and the families touched by our Chapter. The manual will also be used by the Chapter to do in-service training at affiliated institutions and expand the Caregiver Lecture Series. Volunteers on the Speakers Bureau will also benefit from training delivered from the manual.

The Project Staff will be doing another form of outreach as it disseminates the training manual to Virginia State Legislators from the targeted territory. At the Virginia Center on Aging's last Advisory Committee meeting, one legislator who serves on that committee strongly recommended that the project directors engage in public relations and networking with members of Virginia's General Assembly, while promoting the project and its products. Subsequently, the Office of the President at Virginia Commonwealth University called with essentially the same recommendation. The project and its products will also be prominently featured at the Virginia Center on Aging's annual Legislative Breakfast. The project directors hope that this "outreach" will result in expanded dissemination and utilization of the manual and other project products. As legislators certainly fall into the category of "trusted community leaders," it is anticipated that exposure to the training manual content will increase consciousness about the plight of caregivers and perhaps result in more favorable legislation in support of families dealing with dementia.

Capacity Building

Even though the aging network is serving an unprecedented number of older adults, many persons with dementia are "unknown" to the system, and often times family caregivers are struggling alone without knowledge or information about services that could help them. By identifying and partnering with family caregivers, not only can the aging network (both academicians and practitioners) leverage their limited resources dramatically, but family members can "ease the burden" through knowledge of services. The success of the current project points to the effectiveness of a simple intervention undertaken by trained "lay" community members in improving caregivers ability to meet their familial responsibilities through skills training. As caregivers become more self-aware and gain insight about the feelings of those they care for, they become more savvy consumers of formal services and enhance the quality of the informal care they provide.

One of the most gratifying outcomes of the project was the indication that participation in the workshops made caregivers more aware of community resources, improved their knowledge about aging services, and increased the likelihood that caregivers will access formal supports. In some sense, then, trainers became advocates for caregivers and enhanced their abilities to advocate for themselves and their care recipients. As caregivers came to better understand the aging network, they became more capable of navigating the "bureaucratic sea of red tape" and more proficient in dealing with the barriers which can sometimes preclude the delivery of services.

The training materials created for this project not only benefitted from editing for cultural sensitivity, but also assume a unique position among other products in that they are organized according to the progression of dementia. Although much has been written about the stages of dementia, and there is little concordance among various schemata, most educational material remains unrelated to the disease progression or merely makes passing mention of the stages associated with dementia. This may in part be due to the lack of consensus about what the stages are or even how many there are. The approach taken with the materials created for this project circumvent the debate by declaring that there are earlier, middle, and later stages and the content is structured accordingly. In doing so, the information became immediately pertinent to caregivers regardless of how long they have been providing care. Since trainers can market their workshops as pertinent to issues which occur with successive disease stages, caregivers are guaranteed that the instruction they receive will pertain to their particular caregiving situation. For caregiving families who are disenfranchised, unfamiliar with the nature and structure of services in the aging network, or those who are wary of formal service providers, the benefit of a supportive and pertinent educational experience provided by someone they respect and trust can be the first step toward appropriate service utilization. As important as using literacy appropriate materials is when utilizing members of the lay community as trainers, it is doubly important when complex information needs to be translated in a form that is easily understandable and palatable. The emphasis on adult learning theory when training community leaders to conduct workshops should be conducive to an educational experience that is instructional without being tedious.

This project demonstrates that a "train-the-trainer model" can be an effective method for identifying and educating African American and rural caregivers of elders with dementia. The training manual and replication plan developed for the project stand as ready tools for anyone interested in outreach to this population. In addition, the training manual has additional utility, beyond the objectives specified for this project. Much of the information is more generally applicable for non-minority caregivers or those in urban or suburban areas. The manual can also be selectively used with caregivers who have care recipients that are not experiencing cognitive deficits by abstracting the information common to all family caregiving situations. Finally the utility of the manual extends beyond the audience of informal caregivers and can be easily adapted for use with formal caregivers. For example, because the information was intentionally simplified, the manual is a particularly adept tool for in-service training of nurse aides in special care units. To some extent the manual has been field tested for this purpose since one of the project's training sites was at a rural nursing home. The Director of Nurses incorporated the participation of on-site nurses and nurse aids into their annual in-house community service project. Nursing home staff became trainers of other staff, as well as families who had a loved one residing in the facility. The manual will also be used by a faculty member in the Department of Occupational Therapy at Virginia Commonwealth University in a graduate student project to train nurse aides in a Special Care Unit at a Home for Adults.

As the project concludes, staff are gratified by the many ways in which activities initiated by the project are continuing. One rural group of workshop participants continues to meet as a recognized support group since their trainer has received additional instruction in support group leadership from the Alzheimer's Association Chapter Program Director. One rural team of trainers continues to recruit additional caregivers by working through physician referrals after they completed their commitment to the project. Similarly, one African American team that was particularly successful in recruiting as many as 30 caregivers to be educated, communicated their intention to repeat the experience with a new group of caregivers identified through the network of churches in their area. There is no doubt that the project succeeded in building the capacities of persons who remain in their communities as known and active experts in the area of Alzheimer's caregiving.

Evaluation

"If you don't know where you're going, any road will get you there." Although, summative evaluation provides an a posteriori indication of a project's effectiveness and utility, procedural aspects must also be evaluated for successful obtainment of objectives. Planning to evaluate critical steps of the project was an important consideration from its conception. Scrupulous record keeping and the development of evaluation instruments was integral to all activities undertaken. For example, since it was essential that the content of the training manual addressed the needs of African American and rural caregivers and their trainers, both a follow-up questionnaire and a telephone inquiry were used to ascertain whether the results of the nominal group process (see Appendix IV) had indeed, resulted in a comprehensive and relevant curriculum. Similarly, since the composition of the project's RNRTs was a key consideration, this too became part of the formative evaluation of the project. Extensive evaluation of both training levels (Appendices V and VIII) provided the summative evidence necessary to validate the train the trainer model. Monitoring caregiver workshops provided subjective and objective evidence that trainers were following the protocol prescribed in the first level training. Because of the thorough formative and summative evaluation, those who attempt to replicate the project can be assured that the methods and procedures have been field tested and the consequences or results have been verified.

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APPENDICES

Appendix I

Suggested Reading List for Trainers
Central Virginia Caregiver Directory of Resources
Southside Virginia Caregiver Directory of Resources
Certificate of Appreciation for Caregivers

SUGGESTED READING LIST
for Potential Trainers Recruited for the Project
"Assisting Caregivers of Minority and Rural Elders with Dementia:
Progressive Training through Trusted Resources"

Aaronson, M. (1988). Understanding Alzheimer's Disease: What it is, how to cope with it, future directions. New York: Charles Scribners Sons.

Brown, D. S. (1984). Handle with care: A question of Alzheimer's. New York: Prometheus Books.

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Zarit, S., Orr, N. K., & Zarit, J. (1985). The hidden victims of Alzheimer's Disease. New York: New York University Press.

RESOURCE DIRECTORY
FOR FAMILY CAREGIVERS OF
PERSONS WITH ALZHEIMER'S DISEASE

DIRECTORY FOR CENTRAL VIRGINIA

(Defined by the territory served by the Alzheimer's Association Greater Richmond Chapter)

Counties of Amelia, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Essex, Gloucester, Goochland, Hanover, Henrico, King and Queen, King William, Lancaster, Mathews, Middlesex, New Kent, Norththumberland, Powhatan, Prince George, Richmond, Spotsylvania, Surry and Westmoreland; and the cities of Richmond, Colonial Heights, Fredericksburg, Hopewell, and Petersburg.

AREA AGENCIES ON AGING:

Capital Area Agency on Aging
24 East Cary Street
Richmond, VA 22319
Ombudsman: Bette Kerns
(804) 343-3000
1-800-447-6686
Area Served: Counties of Goochland, Powhatan, Henrico, Chesterfield, Charles City Hanover and New Kent. City of Richmond.

Crater District Area on Aging
23 Seyler Drive
Petersburg, VA 23803
(804) 732-7020
Area Served: Counties of Dinwiddie, Sussex, Greensville, Surry, and Prince George. Cities of Petersburg, Hopewell, Emporia and Colonial Heights.

Piedmont Senior Resources Area Agency on Aging
Piedmont Hospital, Bldg 29
2nd Floor, P.O. Box 398
Burkeville, VA 23922
(804) 767-5588
Area Served: Counties of Nottoway, Prince Edward, Charlotte, Lunenburg, Cumberland, Buckingham and Amelia.

Rappahannock Area Agency on Aging
204 Thompson Avenue
Fredericksburg, VA 22405
(703) 371-3375
Area Served: Counties of Caroline, Spotsylvania, Stafford and King George. City of Fredricksburg.

Northern Neck-Middle Peninusula Area Agency on Aging, Inc.
P.O. Box 610 Urbanna, VA 23175
(804) 758-2386
Area Served: Counties of Westmoreland, Northumberland, Richmond, Lancaster, Essex, Middlesex, Mathews, King and Queen, King William and Gloucester.

ALZHEIMER'S ASSOCIATION AND SUPPORT GROUPS

Greater Richmond Chapter Alzheimer's Association
6767 Forest Hill Avenue, #270
Richmond, VA 23225
(804) 320-1101

HELPLINE: 320-HOPE or (outside Richmond) 1-800-598-HOPE

Greater Richmond Area Support Groups-
Monthly support groups provide educational information about Alzheimer's and related disorders, and a place for caregivers to share feelings and coping techniques in a non-judgmental, confidential atmosphere. The following list is sponsored by the Greater Richmond Chapter. This list is subject to change..contact the HELPLINE number if any questions.

Beaufont Towers
3rd Wednesday at 2:00 PM
7015 Carnation Street, (in the Library)
Barbara Mardigian-(804) 272-2918

Downtown
3rd Tuesday at 11:45 AM
Sanger Hall, Room 1-038
Corner of Broad and 11th Streets
Pat Baker (804) 371-5369

Ginter Hall West
2nd Tuesday at 7:00 PM
12411 Gayton Road, Community Room
Natalie Kent (804) 741-9494

Hermitage Home
4th Monday at 1:30 PM
Northwest corner of Westwood Ave and Boulevard
Mary Robinson (804) 643-4018

Lakewood Manor
Last Thursday at 3:00 PM
1900 Lauderdale Drive
Margaret White (804) 740-2900

Lucy Corr Nursing Home of Chesterfield County
3rd Thursday at 7:00 PM
9921 Lucy Corr Court (classroom)
Krista Ratliff, Sarah Erwin (804) 748-1511

St. Edward's
2nd Thursday at 7:30 PM
St. Edward's Parish Center
2700 Dolfield Road
Marion O'Donnell (804) 272-2948

Veterans Administration Medical Center
2nd Saturday at 2:00 PM
1201 Broad Rock Blvd.
Nursing Care Unit Conference Room, Bldg 500
Vivian Bagby (804) 230-001, ext 1945

Westport Convalescent Center
3rd Thursday at 7:30 PM
7300 Forest Avenue, Activities Room, Lower Level
Debbie Monje (804) 358-2253

Adult Children Support Group
Alzheimer's Association
2nd Tuesday at 7:00 PM
Chapter Office
6767 Forrest Hill Avenue, #270
Lynda Gormus (804) 320-0619

Alzheimer's Association Support Groups in the surrounding areas of Central Virginia.

Bowling Green/Caroline County
3rd Tuesday at 7:00 PM
Bowling Green Health Care Center
120 Anderson Avenue
Shirley Crumpler (804) 633-4839

Chilesburg/Caroline County
2nd Wednesday at 10:00 AM
Rehoboth United Methodist Church
18580 Partlow Road
Lila Dolinger (804) 448-3512
Sharon McKenna (804) 752-2115

Colonial Heights
3rd Tuesday at 7:30 PM
Colonial Heights Library, corner of
Conduit Road & Yacht Basin Drive
Robert Barrell (804) 323-1054
Blanche Cootelow (804) 748-5585

Highland Springs/East Henrico
3rd Thursday at 7:00 PM
Henrico Health Care Center
561 North Airport Drive
Jackie Timm, Dawn Sykes (804) 737-0172

Fredericksburg
3rd Tuesday at 12:30 PM
Carriage Hill Nursing Home
5040 Plank Road, Recreation Room
Tina Carter, Mary DePietro (703) 786-4549

Gloucester County
2nd Tuesday at 1:30 PM
Gloucester Senior Center
Main Street in Gloucester Courthouse
Debbie Graham (804) 758-2386

Lancaster County
4th Thursday at 10:30 AM
Rappahannock Westminister Canterbury
in Irvington
Debbie Graham (804) 758-2386

Middlesex County
3rd Thursday at 1:30 PM
Northern Neck Middle Peninusula Area
Agency on Aging
Debbie Graham (804) 758-2386

Petersburg
3rd Thursday at 2:00 PM
Southside Regional Medical Center
801 South Adams Street
5 North Patient Lounge
Lynda Rabon (804) 862-5000
Kim Parrish (804) 861-6977

Richmond County
4th Wednesday at 4:00 PM
Warsaw Health Care Center
Debbie Graham (804) 758-2386

COMMUNITY MENTAL HEALTH FACILITIES AND COMMUNITY SERVICES BOARD

Central State Hospital
P.O. Box 4030
West Washington Street extended
Petersburg, VA 23803
(804) 524-7000
David Chu, Acting Director

Chesterfield Community Services Board
P.O. Box 92
6801 Lucy Corr Court
Chesterfield, VA 23832
(804) 748-1227
Burt H. Lowe, Ph.D., Executive Director

Chesterfield Mental Health Services
21213 Chesterfield Avenue
Ettrick, VA 23803
(804) 520-2270
Joan Carter-Allmond, MSW, Manager
John K. Walden, MSW, Preventive Services Coordinator

Crossroads Community Services Board
P.O. Box 293
Amelia, VA 23002
(804) 561-5057
Margie Crow, LCSW, Clinical Director

District 19 Community Services Board
135 South Adams Street
Petersburg, VA 23803
(804) 861-3700
Richard E. Kellogg, Executive Director

Goochland-Powhatan Community
Services Board
P.O. Box 189
3058 River Road
Goochland, VA 23063
(804) 794-2173
J. Thomas Treece, Executive Director
Bill Desmond, Ph.D., Director of Clinical Services

Hanover County Community
Services Board
P.O. Box 2182
505 South Washington Highway
Ashland, VA 23005
(804) 798-4721
Theresa M. Knott, Executive Director
Steve Alexander, MS, Clinician II, Psychiatric Social Worker

Henrico Area Mental Health &
Retardation Services Board
10299 Woodman Road
Glen Allen, VA 23060
(804) 266-4991
James W. Stewart, III, Executive Director
Dale Mahon, Geriatric Specialist

Medical College of Virginia
Outpatient Psychiatric Clinic
P.O. Box 253, MCV Station
(804) 786-9452
Evelyn Welti, R.N.

Middle Penisula-Northern Neck
Community Services Board
P.O. Box 40
Saluda, VA 23149
(804) 758-5314
Gerald Desrosiers, Executive Director

Petersburg Counseling Service
Petersburg Office
24 South Adams Street
Petersburg, VA 23803
(804) 733-1030
C. Eldon Taylor, Director

Petersburg Counseling Service
Colonial Heights Office
130 James Avenue
Colonial Heights, VA 23824
Eileen J. McHugh, MSW, LCSW, Director

Rappahannock Area Community
Services Board
600 Jackson Street
Fredricksburg, VA 22401
(703) 373-3223
Ronald W. Branscome, Executive Director
Shelia Peters, MA, MH/MR Case Manager

Richmond Community Services Board
900 E. Marshall St., Room 160
Richmond, VA 23219
(804) 780-5876
Lundi S. Martin, Executive Director
Jacob Singer, LCSW, Older Adult Services

DEPARTMENTS OF SOCIAL SERVICES

Amelia Dept. of Social Services
Martha Moyse, Director
Court Street
P.O. Box 136
Amelia, VA 23002
(804) 561-2681 or 561-6040

Caroline Dept. of Social Services
Cynthia J. Green, Director
P.O. Box 430
Bowling Green, VA 22427
(804) 633-5071

Charles City Dept. of Social Services
Byron M. Adkins, Director
P.O. Box 98
Charles City, VA 23030
(804) 829-9207

Chesterfield/Colonial Heights
Dept. of Social Services
Jean T. Smith, Director
9501 Lucy Corr Drive
P.O. Box 430
Chesterfield, VA 23832
(804) 748-1100 or
(804) 796-1837

Cumberland Dept. of Social Services
Paul G. Oswell, Director
Route 60, P.O. Box 33
Cumberland, VA 23040
(804) 492-4915 or 4916

Dinwiddie Dept of Social Services
Peggy McElveen, Director
P.O. Box 107
Dinwiddie, VA 23841
(804) 496-4524

Essex Dept. of Social Services
Arthur M. Irvine, Director
P.O. Box 1004
Tappahannock, VA 22560
(804) 443-3561

Fredricksburg, Dept. of Social Services
John F. Peck, III., Director
608 Jackson Street, P.O. Box 510
Fredricksburg, VA 22404
(703) 373-1032

Gloucester Dept. of Social Services
Evins A. Goodwin, III., Director
P.O. Box 1390
Gloucester, VA 23061
(804) 693-2671

Goochland Dept. of Social Services
Barbara S. Mattice, Director
Administration Annex Building
P.O. Box 34
Goochland, VA 23063
(804) 556-5332 or (804) 784-5510

Hanover Dept. of Social Services
Donna Douglas, Director
P.O. Box 120
Hanover, VA 23069
(804) 537-6060

Henrico Co. Dept. of Social Services
Bettie S. Kienast, Director
8600 Dixon Powers Drive
P.O. Box 27032
Richmond, VA 23273
(804) 672-4001 or 4006

Hopewell Dept. of Social Services
Louis J. Spector, Director
256 East Cawson Street
Hopewell, VA 23860
(804) 748-0151

King & Queen Dept. of Social Services
Joni P. Minor, Director
Courthouse Annex
King & Queen Courthouse, VA 22484
(804) 769-3280
(804) 785-7023

King William Dept. of Social Services
Ben Owen, IV., Director
County Office Building
P.O. Box 187
King William, VA 23086

Mathews Dept. of Social Services
Susan P. Morgan, Director
Route 611, P.O. Box 925
Mathews, VA 23109
(804) 725-7192

Middlesex Dept. of Social Services
Kathryn F. Fitchett, Director
P.O. Box 216
Urbanna, VA 23175
(804) 758-2348

New Kent Dept. of Social Services
Marianne, D. Powell, Director
Route 249, Box 108
New Kent, VA 23124
(804) 966-9625
(804) 730-9550

Northumberland, Co. Dept. of Social Services
Sharon C. Fisher, Director
Health and Social Services Bldg.
P.O. Box 399
Heathsville, VA 22473
(804) 580-3477

Petersburg Dept. of Social Services
Denise P. Dickerson, Interim Director
400 Farmer Street, P.O. Box 2127
Petersburg, VA 23804
(804) 861-4720 or (804) 748-8426

Powhatan Dept. of Social Services
Ann W. Shelton, Director
3908 Old Buckingham Road
P.O. Box 99
Powhatan, VA 23139
(804) 598-5630
(804) 794-9593

Prince George Dept. of Social Services
William F. Gandel, Director
P.O. Box 68
Prince George, VA 23875
(804) 733-2650

Richmond City Dept. of Social Services
Michael A. Evans, Director
Marshall Plaza Building
900 East Marshall Street
Richmond, VA 23219
(804) 780-7430

Richmond County Dept. of Social Services
Christina A. Delzingaro, Director
Chesapeake Building
106 W. Richmond, Street, P.O. Box 35
Warsaw, VA 22572
(804) 333-4088

Spotsylvania Dept. of Social Services
Lorraine V. Lemoine, Director
Route 208, Holbert Bldg
9104 Courthouse Road, P.O. Box 249
Spotsylavania, VA 22553
(804) 582-7065

Surry Dept. of Social Services
Linda Lewis, Director
Route 263
Surry, VA 23883
(804) 294-5240

Westmoreland Dept. of Social Services
Helen B. Wilkins, Director
Peach Grove Lane
P.O. Box 302
Montross, VA 22520
(804) 493-9305

HOME HEALTH CARE

American Critical Care Services
Carolyn McCrockin, Director
221 Ruthers Road
Richmond, VA 23235
(804) 3201113

American Home Care
Rita Schlueter, Administrator
1800 Coyote Drive
Chester, VA 23831
(804) 768-1200

Companion Services, Inc.
2202 Harwood Street
Richmond, VA 23224
(804) 359-1649

Family Care, Inc.
3113 W. Marshall Street, 1-E
Richmond, VA 23230
(804) 358-0111

Henrico Doctor's Hospital, Professional Health Services
Tracy Williams, RN, Home Health Administrator
1602 Skipwith Road
Richmond, VA 23229
(804) 289-4564

Interim Healthcare(use to be Medical Personnel Pool)
Terri Thexton, Director
6856 Midlothian Trnpk
Richmond, VA 23225
(804) 745-7444

INVA Home Health Care
Ann Morrie, Executive Director
908 N. Thompson Street, Suite 100
Richmond, VA 23230
(804) 355-7100

Johnston-Willis Hospital Home Health Care
1401 Johnston-Willis Drive
Richmond, VA 23235
(804) 330-2000 or 2244

Kelly Assisted Living Service, Inc.
Kate Page, Branch Manager
4118-A West Broad Street
Richmond, VA 23230
(804) 353-8501

Kimberly Quality Care
Cindy Rogers, Director
2235 Staples Mill Road
Richmond, VA 23230
(804) 358-3222

Mary Washington Hospital
Home Health Agency
Dianne Tracey, Director
1001 Sam Perry Boulevard
Fredricksburg, VA 22401
(703) 899-1667

Pioneer Home Health Care
Barbara Crosby, Administrator
P.O. Box 1775
2795 South Crater Road
Petersburg, VA 23805
(804) 862-2455

Respite Care Services of Greater Richmond
1010 North Thompson street
Richmond, VA 23230
(804) 354-0719

Southside Regional Medical
Center Home Health Care Division
Deborah Schaefer, Director
801 South Adams Street
Petersburg, VA 23802
(804) 862-5480

Walter Reed Memorial Hospital
Home Health Agency
Ann Tatterson, RN., Nurse Manager
P.O. Box 1130, Route 17
Gloucester, VA 23061
(804) 693-8825

Virginia Center on Aging
January, 1994

RESOURCE DIRECTORY
FOR FAMILY CAREGIVERS OF
PERSONS WITH ALZHEIMER'S DISEASE

DIRECTORY FOR SOUTHSIDE VIRGINIA

Counties of Brunswick, Charlotte, Greenville, Halifax, Lunnenburg, Mecklenberg, Nottoway and Prince Edward; and the Cities of South Boston, Farmville and Emporia.

AREA AGENCIES ON AGING:

Lake Country Area Agency on Aging
1105 West Danville Street
South Hill, VA 23970-3501
(804)-447-7661
1-800-252-4464

Piedmont Senior Resources Area
Agency on Aging
Piedmont Geriatric Hospital
Bldg 29, 2nd Floor
P.O. Box 398
Burkeville, VA 23922-0398
(804) 767-5588

Crater District Area Agency on Aging
120 West Bank Street
Petersburg, VA 23803-3216
(804) 732-7020

ALZHEIMER'S ASSOCIATIONS:

Southside Virginia Chapter Alzheimer's Association
Rt. 1, Box 508A
South Hill, VA 23970
(804) 447-7661

COMMUNITY MENTAL HEALTH FACILITIES:

Southside Community Services Board
424 Cavalier Blvd. P.O. Box 488
South Boston, VA 24592
(804) 572-6916

Piedmont Geriatric Hospital
Burkeville, VA 23922
(804) 767-4401

Crossroads Services Board
P.O. Box 546
Burkeville, VA 23922
(804) 767-5586 or 767-5587

Greensville-Emporia-Sussex
Activities Services Emporia Center
413 Ingleside Avenue
Emporia, VA 23847
(804) 634-3900

DEPARTMENTS OF SOCIAL SERVICES:

Brunswick County Social
Services Department
P.O. Box 89
Lawrenceville, VA 23868
(804) 848-2142

Charlotte County Social
Services Department
Drawer 40
Charlotte Courthouse, VA 23923
(804) 542-5164

Greensville County Social
Services Department
P.O. Box 1136
Emporia, VA 23847
(804) 634-6576

Halifax County Social
Services Department
P.O. Box 666
Halifax, VA 24558
(804) 476-2186

Lunenberg County Social
Services Department
Courthouse Square
Lunenberg, VA 23952
(804) 696-2134

Mecklenburg County Social
Services Department
P.O. Box 400
Boydton, VA 23917
(804) 738-6138

Nottoway County Social
Services Department
P.O. Box 26
Nottoway, VA 23955
(804) 645-8494

HOME HEALTH CARE:

Gillfield-Crater Nutritional Center
(Delivers hot meals)
(804) 732-5287

Commonwealth Home Health
Route 2, Box972
Halifax, VA 24558
(804) 572-1312

Community Memorial
Hospital Home Health Center
P.O. Box 90
South Hill, VA 23970
(804) 447-3151

Home Aid, Inc.
P.O. Box 334
Farmville, VA 23901
(804) 392-4614

Home Recovery, Inc.
110 N. Main Street
Farmville, VA 23901
(804) 392-6650

On-Call Home Care, Inc.
P.O. Box 891
Farmville, VA 23901
(804) 392-6599

Southside Community Hospital
Home Health Service
800 Oak Street
Farmville, VA 23901
(804) 392-8811

Halifax Home Health
2204 Willborn Avenue
South Boston, VA 24592
(804) 575-7961

Stroke Club
Community Memorial Health Center
W. S. Hundley Annex
P.O. Box 90
South Hill, VA 23970
Ask For: Bev Kuyderdall or Sherry Gould
(804) 447-3151
(804) 392-8811

Greensville Memorial Home
Health Care
307 Dogwood Lane
Emporia, VA 23847
(804) 348-2586

Certificate of Appreciation

Virginia Center on Aging
in cooperation with the
Virginia Geriatric Education Center

recognizes

for participating in community workshops

____
Trainer

____
Date

VIRGINIA CENTER ON AGING

Appendix II

Examples of Newspaper Articles about Project/Trainers

News-Progress, Wednesday, April 27, 1994

Woodview Sponsors Free Workshops

SOUTH BOSTON - The Woodview nursing home begins the first in a series of free workshops May 3 for people who want to learn to care for family members at home who have Alzheimer's or other forms of dementia.

The workshop will be held from 6 to 8 p.m. in the conference room at The Woodview.

The workshops are part of an innovative program offered by the Virginia Center on Aging, which is located on the campus of the Medical College of Virginia/Virginia Commonwealth University.

The center designed the project to help rural and/or African American family members learn more about caring for people who have Alzheimer's or other dementias. The project is supported in part by the U.S. Administration on Aging.

Workshops are organized to correspond with the progressive nature of dementia so that caregivers can get the information they need, when they need it. Topics include medications and treatments, legal and financial issues and personal care skills. Those who attend will also learn about communication and behavior problems, safety and environmental adaptations and caring for the "caregiver."

The Woodview, a 180-bed intermediate care facility at 103 Rosehill Drive in South Boston, is one of several localities in central and Southside Virginia to offer the workshops. Five members of The Woodview staff have been trained through the Center on Aging to serve as instructors.

For more information about attending a workshop, contact Winnie Boger, RN, director of nursing, The Woodview, 572-4906, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Health Scene, Spring '94

Workshops For Alzheimer's Caregivers

The Woodview, Halifax Regional Hospital's 180-bed long term care facility, is offering free workshops to train persons who want to care for family members at home who have Alzheimer's or other forms of dementia. Five Woodview staff members, trained through Virginia Commonwealth University's Center On Aging, will serve as instructors. If you're interested in attending a workshop, contact Winnie Boger, R.N. or Angela Richardson, [illegible], 572-4906, The Woodview, 103 Rosehill Drive, South Boston.

Ten The Gazette-Virginian, So. Boston, Va., Mon., April 25, 1994

Workshop At The Woodview

By DONNA STRANGE

The Woodview Nursing Home begins the first in a series of free workshops Tuesday, May 3, for persons who want ot learn to care for family members at home who have Alzheimer's or other forms of dementia. The workshop will be held from 6-8 p.m. in the conference room at The Woodview.

The workshops are part of an innovative program offered by the Virginia Center on Aging, which is located on the campus of the Medical College of Virginia/Virginia Commonwealth University. The Center designed the project to help rural and/or African American family members learn more about caring for persons who have Alzheimer's or other dementias. The project is supported in part by the U.S. Administration on Aging.

Workshops are organized to correspond with the progressive nature of dementia so that caregivers can get the information they need, when they need it. Topics include medications and treatments, legal and financial issues, and personal care skills. Those who attend will also learn about communication and behavior problems, safety and environmental adaptations, and caring for the "caregiver".

The Woodview, a 180-bed intermediate care facility located at 103 Rosehill Drive in South Boston, is one of several localities in central and Southside Virginia to offer the workshops. Five members of The Woodview staff have been trained through the Center on Aging to serve as instructors.

For more information about attending a workshop, contact Winnie Boger, RN, Director of Nursing, The Woodview, 572-4906, Monday

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Brunswick Times-Gazette, Wednesday, April 13, 1994 3

The South Hill Enterprise
May 18, 1994
(2 photos)

Elderly workshop slated

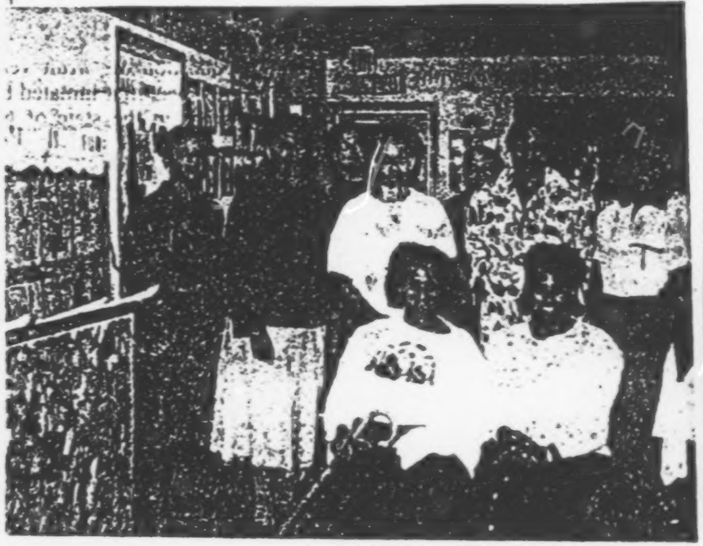
LAWRENCEVILLE — A special workshop for those providing care for the elderly will be held on April 27 at the Tabernacle of Zion Church from 6 to 9 p.m.

This workshop is specifically designed to provide training and information for caregivers of Alzheimer's Disease or older dementia.

Trainers for the workshop are the Rev. Deborah S. Ellerson and Dr. Virginia H. Russell.

The workshop is free of charge and certificates of completion will be available.

The Caregiver's Workshop is sponsored by the Caregiver Project, Virginia Center on Aging and the U.S. Administration on Aging.



May 3, 1994 a Caregiver's Workshop to train persons to care for the
erly was presented at Refuge Church, Alberta. The workshop was
nsored by the Virginia Center on Aging. Virginia Commonwealth
iversity, Richmond. The following persons (not in order) will receive
tificates: Joanna Herritt, Lorraine A. Johnson, Yvonne Z. Williams,
enda McFarland, Rhonda Fitzgerald, Hary A. Halone, Wilma V. Gillis,
lia E. Mason, Agnes Walker Doris Haclin, Lynn E. Hayfield, Vanessa
argrove, Debbie Hargrove, Odelia Gibbs, Donna L. Hargrove. Pre-
nters were Dr. Virginia H. Russell and Rev. Deborah S. Ellison.

for the people had a mind to work
Neh 4:6

On April 27,1994 a Caregiver's Workshop to train persons to care for the elderly was presented at the Tabernacle of Zion, Lawrenceville. The Virginia Center On Aging, Virginia Commonwealth University sponsored the training. The following persons (not in order) will receive certificates: Dorothy R. Stith, Alice D. Hawkins, Rebecca Drumgold, Rhonda Gilliam, Angelia C. Simmons, Arlene Briggs, Patricia Thornhill Harie Powell, Pattie L. Malone, Barbara Kennerson Wilma Harris, Kontarh T. Kogba, Ditamichelle D. Terry Octavia G. Elder, Vivian Reavis, Harie Williams, Barbara Wyche, Helen Wall, Annette Peebles. Presenters were Dr. Virginia H. Russell and Rev. Deborah S. Ellison.

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The Sun —
Clarksville VA

SUPPORT GROUP MEETS — An innovative program to educate rural and/or African American family members caring for elders with Alzheimer's Disease and other dementia is offered by the Virginia Center on Aging at the Medical College of Virginia/Virginia Commonwealth University. The project is supported in part by the U. S. Administration on Aging and is offered locally in communities in Central and Southside Virginia. The program consists of a series of workshops designed to help families learn more about Alzheimer's Disease and other dementia. The Clarksville group of "Caregivers" met Monday night at the Clarksville Public Library. Pictured are: Irene Parish-Director of Nursing Community Memorial Health Center, Hallie Tillotson, Vera Elliott, Ametha Boswell, Madelene Pines, Juanita Hudgins, May Sizemore, George Sizemore, Shirley Jones, and Dorothy Harris-Trainer. Not pictured: Roxie Rosemond, Emma Branch, Patricia Watson, Anne Miller, Vivian Ross, Ollie Fuller, Anna Fuller, Elenora Wysong, Audrey Yulle, and Loretta Harris. (Bob Hart Photo)

Helping hands touch many lives

▼ **AWARDS** *FROM PAGE G1*

for my kids and all the other kids here. I can't stand back and point fingers and watch my community go down."

Fuller

Cheryl Nici

Nici works with the Virginia Home for Boys and volunteers at the Youth Emergency Shelter.

As a volunteer for troubled young people, Nici, 34, listens to problems and fixes those she can. When a young boy threatened to shoot her, she told him: "Someone already tried that and it didn't work. I'm bullet-proof," said Nici, a former Richmomd police officer.

Ten years ago she was shot in the face while on duty at the Richmond Marriott Hotel. She suffered hearing impairment and disfigurement, but her concern for people was undiminished.

"Kids don't need your sympathy. They don't need someone to tell them what to do or give them fairy tales, either. You can't push your values on them, but you can be real. By being real you earn their respect and you can build a relationship."

Herman Melton

Melton thinks all children need a safe haven in which to play under the protection and guidance of caring adults.

Melton

That's why he volunteers at the Sacred Heart Center in the Bainbridge neighborhood about 15 hours a week, supervising children as they play basketball, do crafts, go on field trips and various other activities that "keep them happy and keep them out of trouble."

"I feel safer with them in the center than out on the streets," he said.

Melton grew up next door to the center, which at that time was a school. Three years ago, the Rev. Michael Maruca, a Jesuit priest at Sacred Heart Catholic Church, asked if he would help clean and paint the empty building. Melton, a Baptist, agreed, and began volunteering his time.

When the building was ready to reopen as a community center, he said, "that was a proud moment right then."

Melton, 27 and the father of two, works at Korman Signs, where he does welding and other work.

Dorothy Jones Harris

Harris' community activities were integrated with her career in education, which began in 1937 as a teacher at the old West End High School and ended in 1979 with her retirement as principal of Bluestone Junior High School in Clarksville.

Harris

But Harris, 77, is not slowing down.

She recently organized and helped train blacks and rural residents who care for family members afflicted with Alzheimer's disease and related disorders. Church has been a big part of her life since childhood, and she continues playing the organ and orchestrating activities at Second Baptist Church in Clarksville.

Her volunteer efforts have raised more than $3,000 for the United Negro College Fund to train foreign missionaries.

"I think there are a great many people who are doing the same sort of thing that I'm doing, though some may be more vocal than others," she said.

"There's a whole lot out there that needs to be done. It's just a matter of deciding where you can make a contribution."

Virginia Fones

Fones, a Retreat Hospital volunteer since 1988, averages seven miles of walking down corridors a day, covering more than 23 departments and six nursing stations.

Fones

"Hard work doesn't bother me," said Fones, who considers it a vacation if she takes off the occasional day to go on day trips with the hospital's 55-Plus club, a group for senior citizens.

Though she's not the only volunteer at Retreat in her 80s, she logs more hours than any other volunteer of any age. Her responsibilities include taking specimens to the lab; discharging patients; delivering charts; and distributing mail, sometimes reading letters to older patients.

She doesn't just help patients. "She's very staff-oriented. She wants to make their job easier," said Kathi Lee, coordinator of volunteer services for the hospital, noting Fones' brisk pace, professionalism, willingness to work and ability to listen.

"She's a precious treasure to us in Volunteer Services and to all of Retreat."

The 68 nominations for Community Service Awards were judged by **Susan Crump**, a vice president of planning at United Way Services; **James W. Dunn**, president of the Metropolitan Richmond Chamber of Commerce; **Reginald M. Hill Sr.**, co-chairman of the Tri-Cities Area Coalition on Homelessness; **Johnny Johnson**, president and chief executive officer of Community Pride Stores Inc.; and **James T. Rhodes**, president and chief executive officer of Virginia Power.

Articles on the winners will appear in the Flair section this week, beginning today.

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The Gazette-Virginian, So. Boston, Va., Wed., April 7, 1993

EDUCATION PROGRAM BEGINS— The Woodview recently hosted the first in a series of planning sessions in cooperation with the Virginia Center on Aging and VCU to develop a project to provide education to african-americans and rural families caring for persons with Alzheimer's Disease and related dementias. From left, first row: Dr. Constance Coogle, Ruth Findley, Deborah McDaniels and Jackie Moore. Second row: Helen Carter, Avera Chism, Winnie Boger, Morag Walden, Jim Cavanaugh, Connie Zamora and Walter Chatoney. Project coordinators Coogle and Findley, along with Moore, Virginia Geriatric Education Fellow, met with prospective trainers to discuss the objectives for the project expected to begin in the fall. Those interested in working with the project and for more information should call Walden or Boger at The Woodview, 572-4906.

Planning key to busy volunteer

▼ **AWARD** *FROM PAGE C1*

outreach programs, as well as a program for students who are single parents.

At a recent meeting with the students in the single-parent program, she said, one frustrated young woman discussed how working, taking care of her child and tending to her studies were difficult to manage.

"I said, 'Well, honey, you just got an early start on life, juggling what you need to do with what you want to do. And with planning, you can do it,' " Harris said.

Planning, she says, answers her son's question. And she says her training as a teacher and principal helped her be a successful community leader.

"You have to be able to relate to people," she said. "When you realize that everybody can make a contribution if you give them the opportunity to do so, then you've got everything going for you."

Harris received a bachelor's degree from Talladega College in Alabama and a master's degree from Virginia State University. Her more than 40 years as an educator still manifests itself in Harris' manner, from her poise to her perfect grammar.

When a reporter asks if he can call her with any follow-up questions, she smiles and nods, saying, "I just want it to represent your best effort."

Harris' best efforts are varied. She recently organized and helped train rural residents who care for family members with Alzheimer's disease and related disorders. Church has been a big part of her life since childhood, and she continues to play the organ and orchestrate activities at Second Baptist Church in Clarksville. She also teaches a class at the Lott Carey Foreign Mission.

"She finds time to help the youth of the church and the missionaries develop programs that will strengthen the individual, the home, the church and the community," the Rev. Harper E. Greenhowe wrote The Richmond Times-Dispatch.

Harris frequently speaks in public. She tries to make students at Saint Paul's understand that the opportunity for success exists — they just have to work for it. "The world is your oyster," she said during a recent speech, "but it isn't served on a half-shell."

Harris also serves as district president of the Virginia Retired Teachers Association. Among her goals is helping members realize that life after work can be full and meaningful through community involvement.

"I think there are a great many people who are doing the same sort of thing that I'm doing, though some may be more vocal than others," she said. "There's a whole lot out there that needs to be done. It's just a matter of deciding where you can make a contribution."

Tomorrow in Flair: Richard T. Fuller, a creator of Flunkbusters.

P.O. Box 85613
Richmond, VA 23285-5613
Gazette-Journal
Gloucester-Mathews
Gloucester, VA
C-11,000

FEB 0 6 199[illegible]

Date

Minister Completes Training Course

288

by Bill Nachman

The Virginia Center on Aging has trained 65 individuals from throughout the state to lead community workshops about Alzheimers disease.

Among those who have completed the training is the Rev. Joe Shepherd, pastor of Central and Salem United Methodist churches in Mathews. Mr. Shepherd said he is planning to hold a local Alzheimers workshop this spring at Central.

That session will be aimed primarily at residents in Gloucester and Mathews counties, as well as those living elsewhere on the Middle Peninsula and even in the Northern Neck.

The workshops are being arranged to provide information to individuals worried about their older loved ones who may have Alzheimers disease, which is defined as presenile dementia usually occurring in a middle-aged person and associated with sclerosis and nerve degeneration.

Individuals who are worried about an older loved one who shows the following symptoms may want to attend:

-Frequently confused;

-Forgetful of important things;

-Exceptionally moody;

-Angered at the least little thing;

-Increasing trouble managing money and household tasks, and

-Unable to recall recent events.

Dr. Constance Coogle of the Virginia Center on Aging, located at Virginia Commonwealth University in Richmond, said there are an estimated 88,000-100,000 persons with Alzheimers in the commonwealth.

She said Mr. Shepherd was among those who attended a two-day workshop on Alzheimers issues. Most training was held last fall, with a portion of training held in early January.

The facilitators can help families arranged transportation and adult sitters for their elderly relatives in need, Dr. Coogle said.

For more information, call Mr. Shepherd at 725-3332 or Dr. Coogle at

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Alzheimers Workshop

Workshops for rural and/or African American families caring for loved ones with Alzheimer's disease or other dementias will be conducted at Pleasant Grove Retreat Center in January. The Rev. Alexis Haddix, owner of Pleasant Grove, and Dr. Judith Duncan were trained to provide these workshops under a grant received by the Virginia Center on Aging at MCV/VCU from the U.S. Administration on Aging, Department of Health and Human Services.

With grant funding, Ms. Ruth Finley and Dr. Constance Coogle, affiliated with the Virginia Center on Aging, developed a manual aimed at training persons to improve eldercare services for rural and minority elders with dementia in Central and Southside Virginia. The need for services for elders with dementia has increased because more people than ever are living to the age of risk. About 10 percent of those over 65 years of age have Alzheimer's. Above the age of 85, almost 50 percent may develop the disease. Thus, the number of lay and professional caregivers is increasing.

geted primarily for persons who care for loved ones with symptoms of Alzheimer's or other dementias, any interested persons are encouraged to attend. The workshops will be conducted on January 9, January 16, and January 30, from 2:30 to 5 p.m. There will be no charge for attendance. To register or for additional information on the workshops, call 375-9300 or 375-9302.

VIRGINIA IS
FOR LOVERS

Appendix III

Scheduling Feedback Forms from Trainers
Suggested Reading Lists for Caregivers
Project Director's Workshop Evaluation Form

Scheduling Feedback Form

Please check one of the following options:

_____1. I have scheduled the following workshops to meet:

Workshop 1: Date_______Time_______Place____________________________
(Address, City/County)

Workshop 2: Date_______Time_______Place____________________________
(Address, City/County)

Workshop 3: Date_______Time_______Place____________________________
(Address, City/County)

Workshop 4: Date_______Time_______Place____________________________
(Address, City/County)

_____2. I have not scheduled my workshops yet but will let you know as soon as I have.

_____3. I have already conducted some/all (circle whichever applies) of my workshops and returned evaluation forms for each session.

_____4. I have already conducted some/all (circle whichever applies) of my workshops, and am returning evaluation forms.

NAME & TRAINER IDENTIFICATION NUMBER____________________________

PARTNERING WITH____

trread.mem

Reading List for Alzheimer's Family Caregivers

Constance L. Coogle, Ph.D. & Ruth B. Finley M.S.
Virginia Center on Aging

Alzheimer's Disease Center, University of Southern California (1991). Improving caregiving skills: The stress reduction method. Distributed by the Alzheimer's Disease Education and Referral Center, P.O. Box 8250, Silver Spring, MD, 20907-8250.

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Reading List for Family Caregivers

Constance L. Coogle, Ph.D. & Ruth B. Finley, M.S.
Virginia Center on Aging

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Project Directors' Evaluation of Selected Training Sessions

Date:________________ Coogle____ Finley____

Trainers:____

Place:____________________________________Time:________until_____

Session # (circle) 1 2 3 4 5 6

List modules presented & circle if a required module:__________________________________

PROGRAMMATIC ASPECTS	Outstanding	Satisfactory	Needs Work
Facilites/environment	________	________	________
Welcoming/introductory remarks	________	________	________
Administration of Caregiver Survey	________	________	________
Administration of Pre-post Tests	________	________	________
Administration of Session Evaluations	________	________	________
Pre-post ?'s covered in mini-lecture	________	________	________
Level of knowledge	________	________	________
Evidence of preparation	________	________	________
Closure	________	________	________
INTERPERSONAL ASPECTS			
Leadership ability	________	________	________
Respect for caregivers	________	________	________
Rapport with caregivers	________	________	________
Problem-solving ability	________	________	________

TEACHING OPTIONS

	Yes	No	Comments
Refreshments?	____	____	____________________
Video or other A-V's?	____	____	____________________
Experiential exercises?	____	____	____________________
Hand-outs?	____	____	____________________

How many caregivers were present?______ Of these, how many African-Americans?_____

What were the best features of the session?

What aspects of the session could be improved?

Appendix IV

Results of Nominal Group Process - Central Virginia
Results of Nominal Group Process - Southside Virginia
Regional Needs and Resources Teams Questionnaire

RESULTS OF NOMINAL GROUP PROCESS
TRAINING TOPICS
CENTRAL REGIONAL NEEDS AND RESOURCES TEAM (N=14)

1st Most Important Training Topic (Average rating = 4.14)[1]
Emotional and Psychological Consequences of Caregiving

1. Recognizing and coping with caregiver strain
2. Potential for elder abuse as a consequence of caregiver strain
3. Potential for alcohol abuse as a consequence of caregiver strain
4. Other mental health consequences of caregiver strain (i.e., depression)
5. Role overload (i.e., "sandwich generation")
6. "Role reversal" (especially in African American families where elder is symbol of strength for the family)
7. Cultural differences in the therapeutic relationship

2nd Most Important Training Topic (Average rating = 3.50)
Caregiver Supports

1. Building support for the caregiver (helping other family members understand)
2. Acceptability of accessing resources and how to make it easier
3. Involving other family members to share responsibility
4. People, organizations to consult with
5. Using volunteers to help families (AARP)
6. Alzheimer's Disease Chapter helplines (320-HOPE & 1-800-598-HOPE)
7. Gender-specific suggestions (i.e., tips for male caregivers)

3rd Most Important Training Topic (Average rating = 3.36)
Basic Clinical Information

1. Disease process and symptoms, stages (nature of "stage")
2. Coping with difficult behaviors (tie in with symptoms)
3. Medications available and physicians
4. Diagnosis

---

[1] Average ratings range from "1" (least important) to "5" (most important)

4th Most Important Training Topic (Average rating = 2.14)
Safety

1. Medication Management
2. Home reorganization/environmental modifications

5th Most Important Training Topic (Average rating = 1.86)
Legal/Financial Issues

1. Making placement decisions (problem of distance for rural families)
2. Financial considerations
3. Alternative options (creative decision-making)
4. Power of attorney and guardianship
5. Asset management/estate planning
6. Dealing with funeral homes (pre-death planning)

RESULTS OF NOMINAL GROUP PROCESS
TRAINING TOPICS
SOUTHSIDE REGIONAL NEEDS AND RESOURCES TEAM (N=15)

1st Most Important Training Topic (Average rating = 6.67)[1]
Disease & Treatment

1. Course of the disease
2. Behaviors to be expected
3. Distinguish between "healthy" aging & disease (diagnostic issues)
4. Myths about Alzheimer's Disease (AD)
5. Nutritional needs of Alzheimer's patients
6. Current medications and interventions
7. Behavior management medications
8. Side effects of medication
9. AD is not preventable
10. Understanding disease vs. personality of patient
11. Acceptability of asking questions of professionals
12. Importance of a thorough evaluation prior to diagnosis

2nd Most Important Training Topic (Average rating = 5.07)
Patient Behaviors & Interventions

1. Distinguishing resistive vs. aggressive patient behavior
2. Filial/spousal "role reversal" (dignity/respect)*
3. Empathy for patient's perspective
4. Strategies to deal with patient's behavior
5. Helping caregivers utilize patient strengths
6. Communicating with the patient
7. Safety issues
8. Environmental adaptation (providing stimulation/reorganizing household)*
9. Loss of power and human dignity
10. How to handle crisis situations
11. How to prevent crisis situations
12. Cognitive and emotional aspects of making decisions about institutionalization when and if needed*
13. Least restrictive environment (wandering)
14. Sensitivity to patient needs, avoiding pity

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[1] Average ratings range from "1" (least important) to "7" (most important)

3rd Most Important Training Topic (Average rating = 4.47)
Impact on Caregivers & Family

1. How caregivers can deal with their feelings
2. How caregivers need to care for their own emotional needs
3. Unintentional abuse and neglect
4. How caregivers can learn to accept help and accept their feelings of being overwhelmed and in need of help
5. How caregivers need to care for their own physical needs
6. How to deal with other family members
7. How to deal with stigma of Alzheimer's Disease in the community
8. Impact of Alzheimer's Disease on family
9. Fear of familial Alzheimer's Disease
10. Filial/spousal role reversal (dignity/respect)*
11. Coping with grief
12. Helping caregivers define their own support network*
13. Whose problem is it (caregiver vs. patient)?
14. Shared experiences
15. Long distance caregiving
16. Family caregiving in the nursing home

4th Most Important Training Topic (Average rating = 3.93)
Caregiver Interventions

1. Importance of humor
2. Ideas for activities to involve the patient
3. Environmental adaptation (providing stimulation/reorganizing household)*
4. Reality orientation therapy (how far to go)
5. Validation therapy
6. Importance of tender, loving care
7. How to help with physical care (Activities of Daily Living)
8. How to ask questions of health care professionals/service providers

5th Most Important Training Topic (Average rating = 3.27)
Resources

1. Respite Care
2. Understanding patient fears and confusion
3. How to help build up support network
4. List of resources
5. Evaluation of resources list (discussion of special care units & brochure developed by Geriatric Services, State Dept. of MHMRSAS; agencies should be described in terms of relevant services offered)
6. Explanation of support groups
7. Alzheimer's Chapter Helpline; other hotlines
8. Advocacy (Area Agencies on Aging as advocates)
9. Developing a "sponsor" network similar to Alcoholics Anonymous
10. Meeting spiritual needs
11. How to deal with bureaucracy
12. Cognitive and emotional aspects of making decisions about institutionalization when and if needed*
13. Helping caregivers define their own support network*

6th Most Important Training Topic (Average rating = 3.07)
Legal/Financial/Patient Competency

1. Legal aspects (wills, living wills, guardianship, fiduciary & health care power of attorney)
2. Financial support
3. Financial and legal aspects of making decisions about institutionalization when and if needed*

7th Most Important Training Topic (Average rating = 1.20)
Placement Options/Continuum of Care

1. How to plan for least restrictive environment when physician recommends nursing home placement
2. Cognitive, emotional, financial, and legal aspects of making decisions about institutionalization when and if needed*

* = issue included in more than one topic

NAME____________________________________

REGIONAL NEEDS AND RESOURCES TEAMS QUESTIONNAIRE

The questions which follow pertain to the Virginia Center on Aging's project to educate family caregivers of rural and/or African American elders with dementia. Please take a few minutes to respond to the questions which follow. Your suggestions and advice are very important to us, so please take a few moments now, while you have the questions in front of you.

1. How successful was the nominal group process in helping us identify important training topics and information useful to family caregivers? (Circle one response)

   0 = Could not attend meeting
   1 = Not Very Successful
   2 = Somewhat Successful
   3 = Very Successful

2. Are there any other important training topics or information useful to family caregivers, not mentioned on the enclosed list of results, that should be included in the training curriculum? If yes, what other information or topics should be included?

   ____
   ____
   ____
   ____

3. Are you interested in being a trainer of caregivers for this project? If yes, what are your qualifications? **Remember: we are looking for individuals who are knowledgeable of caregiver issues and informational needs, connected with caregiver networks locally, or capable of recruiting potential caregiver trainees.**

   ____
   ____
   ____
   ____

4. Do you know of others who would be interested in being a trainer of caregivers for this project? If yes, who are they and how may we contact them?

   ____
   ____
   ____
   ____

5. Do you know of or have access to minority or rural caregivers who could benefit from the educational workshops?

Yes No

6. Do you know of others who have access to minority or rural caregivers who could benefit from the educational workshops? If yes, who are they and how may we contact them?

____

____

____

____

7. Would you be interested in developing a training module in your particular area of expertise for use in training the trainers or caregivers? If yes, what topic area?

____

____

____

____

8. Do you know of others who would be interested in developing a training module in their particular area of expertise for use in training the trainers or family caregivers? If yes, who are they, how may we contact them, and what is their area of expertise?

____

____

____

____

9. Would you be interested in reviewing/editing the training curricula developed to insure that it is comprehensive, culturally sensitive, and literacy appropriate?

Yes No

Please be sure that you have written your name at the top of the first page. Please return your questionnaire in the self-addressed stamped envelope (SASE) enclosed as soon as possible. Thank you for your support!

Appendix V

An Evaluation of First Level Training

Appendix V-A: Original Pre-Training, Post-Training Questionnaires
Two-Day Training Evaluation Questionnaire
Appendix V-B: Revised Pre-Training, Post-Training Questionnaires

ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

AN EVALUATION OF FIRST LEVEL TRAINING

by

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ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

An Evaluation of First Level Training

Training participants were asked to attend two-full days of training in order to partially prepare for conducting their caregiver workshops. In order to assure maximum attendance at training sites, potential trainers were given the option of attending four separate training sessions held in various locations within the targeted territory. Two-day training sessions were scheduled at four different sites and trainers could select to attend whichever sites and dates were most conducive to their schedules. In order to accommodate trainers who could not take two full days from work to attend training, one of the two training days was scheduled on a holiday (Veteran's Day).

Upon arrival at the training site, trainers were given a 374-page training manual. This extensive manual contains six chapters which supplements the content of training sessions and 21 modules or Caregiver Lesson Plans. The six chapters include: 1) an introduction which delineated the purpose and rationale of the project, 2) an overview of dementia and caregiving issues; 3) a review of adult learning principles, with an emphasis on older adult learners; 4) a discussion of the special strains and strengths of African American caregivers; 5) a detailed summary of issues in rural aging with specific tips for trainers working in rural areas; and 6) a thorough tutorial on recruiting caregivers and conducting caregiver workshops. Nine key or core modules were chosen and designated as required modules to be included as part of each workshop series while the other modules were designated as elective to be covered at the trainers' discretion. Each module was structured with a workshop goal, rational, and educational objectives in addition to a mini-lecture, suggested audio-visual resources, experiential exercises and/or camera-ready caregiver handouts, and suggested readings. Training packages also included caregiver workshop evaluation materials, pre-paid envelopes for returning evaluation materials, and certificates of completion to be awarded to caregiver participants. Additional training materials included a variety of pamphlets and brochures from national and local service agencies concerned with caregiving, Alzheimer's Disease, minority health, and other pertinent topics.

Presenters with expertise in each of the major training content areas were recruited to conduct the two-day training sessions. Since the success of the project rests largely upon the quality of the training provided to and by these participants, members of the local Alzheimer's Association were recruited to supplement the expertise provided by the project staff. In addition, local community resource panels were assembled to inform trainers of the variety of services available in their area that would be beneficial to their caregiver participants.

For the first training day (Day A), content included:

1) a review of the project's purpose and rationale;
2) an overview of Alzheimer's disease and dementia;
3) sensitivity training covering relevant caregiving issues;
4) a demonstration of adult learning principles; and
5) specific instruction on how to identify and recruit caregivers, find a training site, conduct the workshops, and collect evaluation information;

The agenda for the second training day (Day B) covered:

1) some precautionary notes about encounters with instances of unintentional abuse or benign neglect;
2) special considerations for trainers of rural caregivers;
3) presentations by representatives from relevant service organizations; and
4) developing ethnic competence for cross-cultural training.

The two-day training session concluded with a role-play, demonstrating how an actual workshop might be conducted.

The training was evaluated in terms of the effect of education and training on the knowledge levels of trainers, and the overall effectiveness and utility of the information provided. On each training day, participants were asked to complete pre-training and post-training knowledge tests, and to evaluate the training experience in terms of the extent to which the training was personally and professionally applicable and useful. Participants were also asked to rate the general effectiveness of the training content and presenters, and the quality of the program materials. They were given the opportunity to provide comments through the inclusion of open-ended questions concerning the most and least helpful aspects of the training, and to indicate any relevant issues not included in the training. The training evaluation instrument, and the Pre-Training and Post-Training knowledge tests for each training day are included in Appendix A. A summary of the results of data analyses performed on the responses received follows.

Demographic Characteristics

Table 1 shows the frequencies and percentages of those who participated in the two-full days of first level training of trainers. A total of 58 persons provided demographic data in four separate locations. Because trainers could choose to take the first day of training in one site and the second day at a different site, frequencies for site participation are listed separately for the first (Day A) and second (Day B) training days. For both the first and second training days, almost half of those trained attended in Richmond. Because of its remote location, only a few participants (n=6) attended training in South Boston.

Trainers were predominantly African American (65.5%) and disproportionately female (82.8%). When asked to indicate whether they worked or practiced in a rural or urban area, the majority of those who responded (64.3%) chose "rural". The trainers tended to be well educated, with almost half possessing advanced degrees. Almost one-quarter of trainers were social workers (24.1%), and more than one-quarter (31.5%) were nurses. Other disciplinary areas included gerontology, theology, education, psychology, recreational or occupational therapy, and business administration. Occupations were quite diverse, with the largest category (14.0%) being management, followed by community service agency personnel, nursing home staff, and pastors or ministers (10% each). Practice settings were equally variable, with the most popular being a community or social service agency (16.1%).

Overall Evaluation

Participants were asked to use a 1-5 Likert-type scale (with 1 representing "not at all" and 5 representing "to a great extent") to indicate the overall effectiveness of the training and the extent to which their expectations had been met. **Table 2** displays the average rating provided by all respondents, the associated standard deviations, and the numbers of respondents for each question asked on the first and second training days. **Table 2** also shows the average obtained for the two-days combined. In general, the training was well-received since the means for all questions fell between 4 and 5 when both training days were considered together. The lowest scores were given for the questions regarding: 1) the extent to which the program helped with trainers' problem-solving skills, and 2) the extent to which the program affected trainers' views about caregivers' quality of life. Since the training was not directly aimed at producing improvements in these two issues, the changes documented are remarkable.

Open-Ended Evaluation

Four open-ended questions were included to allow participants to generate their own comments with regard to what they found most and least helpful about the training. The 374-page training manual was regarded as the most helpful aspect by 18.8% of the respondents, and 10.4% indicated that every aspect of the training was helpful. The overview of dementia and Alzheimer's Disease, the instruction about how to use the manual, and the supplementary handouts provided were each regarded as most helpful by 10.4% of respondents. Others mentioned the speakers, the discussion of adult learning principles, the instruction on how to conduct workshops, and the opportunity for group discussion as the most helpful aspect of the training. When asked about the least helpful aspect of the training, almost half of respondents indicated that there was no aspect that was not helpful. A few respondents (12.1%) expressed a desire for more group discussion, while others mentioned the evaluation paperwork (9.1%) and the physical environment (9.1%).

When asked if there were relevant topics not covered in the training, suggestions were offered by 13 of the trainers. The suggestions included death and dying, elder abuse (although this was specifically addressed), health promotion, case management, community-based care, women's issues, group process, depression, loneliness, recreation, arthritis, and developmental disabilities.

Knowledge Gains

Knowledge test items were drawn from information to be presented in the training sessions. On Day A, participants were asked to answer 9 multiple choice questions and 4 true-false items. The pre-training and post-training questionnaires for Day B included 8 multiple choice questions and 6 true-false items.

To demonstrate knowledge gains, pre-training and post-training questionnaires were scored by assigning a "1" for correct answers and "0" for incorrect answers. Total scores were computed by summing across the test items for each day, so that the maximum score possible was "13" for Day A and "14" for Day B. The minimum possible was 0, indicating that all items were answered incorrectly. **Table 3** shows the results of dependent t-tests comparing the overall pre-training and post-training scores for each training day.

Day A. Prior to the training on Day A, the average percent score was 52.6% (S.D. = 14.28). That is, participants answered 6.84 of the 13 questions correctly on the average. After training, average percent scores increased to 71.2% (S.D. = 17.68) or 9.25 items correct on the average. This constituted **a statistically significant gain in knowledge** ($t = 8.34$; $p = .0001$). Prior to training, almost 70% of the participants answered less than 60% of the questions correctly. After training however, all but 16% of respondents (i.e., 84%) scored 60% or higher.

Day B. Prior to the training on Day B, the average percent score was 64.9% (S.D. = 13.21). That is, participants answered 9.08 of the 14 questions correctly on the average. After training, average percent scores increased to 70.9% (S.D. = 14.78) or 9.92 items correct on the average. This constituted **a statistically significant gain in knowledge** ($t = 3.43$; $p = .0012$). Prior to training, almost 40% of the participants answered less than 60% of the questions correctly. After training however, all but 22% of respondents (i.e., 78%) scored 60% or higher.

Table 4 shows an examination of knowledge gains for only low-scoring participants who answered less than 65% of the items correctly on the pre-training test. For Day A, 45 respondents met this criteria. A substantial and statistically significant increase in their average scores on the knowledge test before and after training was found ($t = 8.53$; $p = .0001$). The mean pre-training score was 47.2% (*S.D.* = 9.65), while the average score after training for these participants was 68.7% (*S.D.* = 18.51). Although the gains for Day B were not as large as the previous training day, they are statistically significant ($t = 3.75$; $p = .0009$). The mean pre-training score was 55.0% (*S.D.* = 8.12), while the average score after training for these participants was 63.8% (*S.D.* = 13.72).

In order to further analyze the knowledge gains achieved, an examination of pre-training and post-training performance by item was conducted. **Table 5** shows the results of these analyses for Day A. In order to compensate for inflated alpha levels with the conduct of numerous t-tests, the level of significance was set at .01 for purposes of the item analyses. Applying this criterion, statistically significant improvements in knowledge were found with regard to the following: the incidence of Alzheimer's Disease among elders 85 and older (Item 1), the definition of Alzheimer's Disease (Item 3), the conditions accompanying and related to Alzheimer's Disease (Item 5), the appropriate ways to teach adults (Item 8), learning difficulties that may occur in older adults (Item 9), the curvilinear relation between caregiver burden and recipients' level of cognitive functioning (Item 10), and the independent relation between caregiver burden and support group participation (Item 11). In addition, one item was statistically significant at the .05 alpha level, suggesting gains in knowledge with regard to autopsy as the conclusive method of diagnosing Alzheimer's Disease (Item 4). For three of the four items which were not statistically significant (Items 2, 6, & 12), more than 80% of the participants answered the item correctly on the pre-test, leaving little room for improvement. The item concerning the independent relation between objective and perceived burden (Item 13) could be regarded as too difficult, since less than 20% of respondents answered correctly either before or after training. For one item (Item 7; the nature of caregiver burden), respondents showed a significant *decrease* in knowledge, that is, the percentage of respondents providing the correct answer was *lower* after the training. This may have been due to confusion related to the wording of the question. Some participants may have failed to distinguish between the effect of support from family and friends versus a support group as these two constructs relate to caregiver burden.

Table 6 shows the results of knowledge gains by item for Day B. Employing the conservative level of significance of .01, statistically significant improvements in knowledge were found with regard to the precipitants of nursing home placement (Item 8) and the greater reliance on prayer and religion among African American caregivers (Item 14). In addition, one item approached statistical significance at the .05 alpha level, suggesting gains in knowledge with regard to the barriers to minority service utilization (Item 1). The majority of the test items for Day B were not associated with statistically significant improvements in knowledge.

It should be pointed out that most of the information covered on Day B was presented by guest speakers who may not have been as careful as the project staff to cover points contained in the knowledge test. For five of the items which were not statistically significant, more than 80% of the participants answered the item correctly on the pre-test, leaving little room for improvement. The item concerning the degree of extended-family caregiving among African Americans (Item 3) could be regarded as too difficult, since less than 10% of respondents answered correctly either before or after training. Two items, the participation in support groups among urban versus rural caregivers (Item 7) and the greater functional impairment among African American nursing home residents (Item 12), were confusing to trainers and resulted in average post-tràining scores that were lower than pre-training scores. It should be noted that this was not a statistically significant reverse of the expected finding, however.

Item Analysis

The value of a testing instrument rests in its questions or items. Some test items may be more effective than others in reflecting true levels of knowledge. That is, some are more likely to be answered correctly by those who performed best on the overall test. Conversely, some items may be answered incorrectly by the best-scoring respondents. Any attempt to evaluate the functional utility of a testing instrument should be based on this kind of determination. Also, when developing or streamlining a test for future use it is important to know which items may be excluded. In general, those items which show the greatest degree of discriminative ability between high, moderate, and low scoring respondents should be retained, while those which result in approximately equal proportions of correctly-scoring respondents in each scoring group should be dropped.

Day A

For the item analyses examining responses to the knowledge test on the first training day (Day A), respondents were categorized into three groups based on their total scale scores. Although it would have been desirable to set criterion cut-off points so that each subgroup would contain roughly one third of the participants, this was not possible due to the distribution of scores. In order to insure some variability of response in terms of the individual items, those scoring 11 or more were assigned to the high group, those scoring 8 or less were assigned to the low group, and respondents answering 9 or 10 questions correctly on the post-training knowledge test were assigned to the moderate group. After setting these criterion cutoff points, 23.2% of respondents constituted the low-scoring group, 46.4% of respondents were designated as scoring in the moderate range, and the remaining 30.4% comprised the high-scoring group. The mean for the low-scoring group was 5.85 (or 44.9% correct) and the standard deviation was 1.82. For the moderate-scoring group, the average was 9.5 (or 73.1% correct) and the standard deviation was 0.51. The high-scoring group had a mean of 11.47 (or 88.2% correct) and the standard deviation was 0.72. Analysis of variance revealed that the three scoring groups differed significantly in terms of their post-training performance on the knowledge test; F (2, 53) = 114.94, p = .0001.

Table 7 shows the results of the item analyses performed for the 56 respondents. An item was deemed as ideally discriminating when the majority of low scorers answered incorrectly, the majority of high scorers answered correctly, and approximately half of the moderate scorers answered correctly. Employing these criteria, two items showed ideal discriminative ability. The questions concerning the incidence of AD among elders 85 years of age and older (Item 1), and the independent relation between caregiver burden and support group participation (Item 11) yielded the best discrimination among respondents. For Item 7 (the nature of caregiver burden) the percentage of correct respondents increased linearly across the low, moderate, and high scoring groups. That is, the low-scoring group had the lowest percentage of respondents with correct answers, the moderate scoring group had the next highest percentage of correct responding members, and the high scoring group had the greatest percentage of correct scoring respondents. Ideal discrimination was not achieved however, since more than one-half of the moderately scoring respondents answered correctly. The majority of items (2, 3, 4, 5, 6, 8, 9, & 12) failed to discriminate between the high and moderate scorers, although a smaller proportion of those in the low scoring group answered these items correctly. Of these, Items 3, 5, and 8 were marginally better since less than half of the low scorers answered correctly. Conversely, Items 2, 4, 6, 9, & 12 were marginally worse since more than half of the scorers in each group answered correctly. Both of these trends were deemed acceptable, however, since at least one scoring group was distinguished from the other two. Since the vast majority of respondents in the low and moderate scoring groups (and more than half of the high scorers) answered Item 13 (independent relation between objective and perceived caregiver burden) incorrectly, this test question was deemed unacceptable. Item 10 (the curvilinear relation between caregiver burden and recipient's level of cognitive functioning) was also revealed to be unacceptable since less than one-quarter of the moderate scorers answered correctly, even though the scoring trend for high and low scorers was as expected. **In sum, two items showed ideal discriminative ability and clearly discriminated between the three groups, one item showed a linear increase in correct respondents across the three groups, eight items discriminated at least one scoring group from the other two, and two items were regarded as irregular and unacceptable. Appendix B contains the revised knowledge tests for Day A.**

Day B

For the item analyses examining responses to the knowledge test on the second training day (Day B), those scoring 12 or more were assigned to the high group, those scoring 8 or less were assigned to the low group, and the remaining respondents were assigned to the moderate group. After setting these criterion cutoff points, 22.0% of respondents constituted the low-scoring group, 54.0% of respondents were designated as scoring in the moderate range, and the remaining 24.0% comprised the high-scoring group. The mean for the low-scoring group was 7.00 (or 50.0% correct) and the standard deviation of 1.89. For the moderate-scoring group, the average was 9.96 (or 71.1% correct) and the standard deviation was 0.94. The high-scoring group had a mean of 12.50 (or 89.3% correct) and the standard deviation was 0.67. Analysis of variance revealed that the three scoring groups differed significantly in terms of their post-training performance on the knowledge test; $\underline{F}$ (2, 47) = 113.52, $\underline{p}$ = .0001.

Table 8 shows the results of the item analyses performed for the 50 respondents. Four items showed ideal discriminative ability. The questions concerning the relative proportion of the population that is elderly in metropolitan/non-metropolitan areas (Item 6), the precipitants of nursing home placement among African American caregivers (Item 8), the under-utilization of community mental health services by rural elderly (Item 10), and the greater functional impairment among African American nursing home residents (Item 12) yielded the best discrimination among respondents, with the majority of low scorers answering incorrectly, the majority of high scorers answering correctly, and approximately half of the moderate scorers answering correctly. For Items 1 and 4 (concerning the barriers to minority and rural service utilization), the percentage of correct respondents increased linearly across the low, moderate, and high scoring groups. That is, the low-scoring group had the lowest percentage of respondents with correct answers, the moderate scoring group had the next highest percentage of correct responding members, and the high scoring group had the greatest percentage of correct scoring respondents. Ideal discrimination was not achieved however, since more than one-half of the moderately scoring respondents answered correctly. Several items (5, 11, & 13) failed to discriminate between the high and moderate scorers, although a smaller proportion of those in the low scoring group answered these items correctly. Even though more than half of the scorers in each group answered correctly, this trend was still deemed acceptable, however, since at least one scoring group was distinguished from the other two. In a similar fashion, Item 7 failed to discriminate between the low and moderate scorers. Since a greater proportion of those in the high scoring group answered this item correctly, however, the trend was regarded as acceptable. Four items were revealed to be wholly unacceptable, yielding little or no discriminative ability. Items 2, 9, and 14 could be regarded as "too easy", as the proportion of correctly-scoring respondents was uniformly high. Item 3 appeared to be "too difficult", since less than 20% of respondents in each scoring group answered the question correctly. **In sum, four items showed ideal discriminative ability and clearly discriminated between the three groups, two items showed a linear increase in correct respondents across the three groups, four items discriminated at least one scoring group from the other two, and four items were clearly unacceptable. Appendix B contains the revised knowledge test for Day B.**

Internal Reliability

The pre-training and post-training knowledge tests were examined to obtain an estimate of internal reliability. Cronbach's alpha coefficients were computed in order to yield an estimate of within test item consistency. For the thirteen items included on the knowledge test for the first training day (Day A), the standardized item alpha coefficient was .3986 for the pre-training test and .6779 for the post-training test. For the 14 items included on the knowledge test for the second training day (Day B), the standardized alpha coefficient was .3411 for the pre-training responses and .5631 for the post-training responses. Given the abbreviated length of the knowledge tests and the limited sample sizes employed, acceptable internal reliability was achieved.

Further Analyses of Knowledge Gains

Knowledge Gains by Training Site

Performance on the knowledge tests was examined separately by site to determine if gains in knowledge were achieved during all training sessions conducted. **Table 9** summarizes the results of dependent t-tests comparing the overall pre-training and post-training scores for each training day at each of the four training sites.

For the first training day (Day A) statistically significant improvements in knowledge were documented for all sites except South Boston. This site was unique in that: 1) only six participants completed both the pre-training and post-training knowledge tests, 2) the participants were all nurses or nurses aides working at a rural nursing home, and 3) attendance at the training was perceived in some respects as an in-service opportunity.

For the second training day (Day B) statistically significant improvements in knowledge were documented only at the Richmond site. This site was distinguished in that: 1) it was the most widely attended, 2) participants were primarily urban, African American trainers, and 3) the other training sites were predominated by rural trainers.

Differences between knowledge gains demonstrated during the two training days can be attributed in part to the training content included. The second training day involved extensive use of guest speakers (i.e., the community resources panel and experts in the areas of rural aging and cultural competence). If the information being asked for on the knowledge test was not sufficiently emphasized by the guest speakers, performance would have been compromised. The limited ability to demonstrate knowledge gains during the second day of training may in part be due to this reliance on outside speakers.

Site Comparison of Knowledge Gains

Table 10 summarizes the results of analyses of covariance comparing the four training sites in terms of the knowledge gains achieved during each training day. For the first training day, a statistically significant site difference was obtained; F (3, 51) = 5.54, p = .0023). Participants at the South Boston site scored significantly lower on the post-training test (after controlling for pre-training differences) than participants at any of the other three sites. A similar difference in performance was noted for the second training day as well; F (3,45) = 3.50, p = .0230. In general, South Boston participants failed to provide correct answers to about half of the post-training test items, while trainers at the other sites scored correctly on between two-thirds and three-quarters of the knowledge test items.

Site Category Comparison of Knowledge Gains

The training sites employed can logically be combined into categories based on the composition of attendees. The Richmond site constitutes a predominantly urban site, while the Lawrenceville and South Boston sites can be collapsed to form a predominantly rural site category. The Chester site was essentially mixed in terms of rural and urban participation. **Table 11** summarizes the results of analyses of covariance comparing the three training site categories in terms of the knowledge gains achieved during each training day. A statistically significant site difference was obtained for the first training day; F (2, 52) = 5.84, p = .0052). Participants at the rural sites (South Boston & Lawrenceville) scored significantly lower on the post-training test (after controlling for pre-training differences) than participants at any of the other urban or mixed sites. A similar difference in performance was noted for the second training day as well; F (2,45) = 3.56, p = .0367. In general, rural participants failed to provide correct answers to about one-third of the post-training test items, while trainers at the urban and mixed sites scored correctly on three-quarters of the knowledge test items.

Ethnic Group Comparison of Knowledge Gains

Table 12 summarizes the results of analyses of covariance comparing the knowledge test performance of Caucasian and African American trainers during each training day. A statistically significant site difference was obtained for the first training day; F (1, 53) = 5.35, p = .0247). Caucasian participants scored significantly higher on the post-training test (after controlling for pre-training differences) than African American participants. A similar difference in performance was noted for the second training day as well; F (1,47) = 4.37, p = .0421. On the average, non-minority trainers provided correct answers to about three-quarters of the post-training test items, while African American trainers scored correctly on approximately two-thirds of the knowledge test items.

Education Category Comparison of Knowledge Gains

For comparative purposes, trainers were classified according to their levels of education. **Table 13** summarizes the results of analyses of covariance comparing the knowledge test performance of trainers with bachelor degrees, advanced degrees, and no four-year degrees for each training day. A statistically significant educational group difference was obtained for the first training day; $\underline{F}$ (2,51) = 5.82, $\underline{p}$ = .0053). Trainers who had not obtained a four-year college degree scored significantly lower on the post-training test (after controlling for pre-training differences) than those with such credentials. A similar difference in performance was noted for the second training day as well; $\underline{F}$ (2,45) = 4.48, $\underline{p}$ = .0168. Non-degreed trainers answered less than two-thirds of the post-training test items correctly on the average, while trainers with degrees scored correctly on approximately three-quarters of the knowledge test items.

Area of Work or Practice Comparison of Knowledge Gains

Trainers were asked to indicate whether they worked or practiced in an urban or rural area. **Table 14** summarizes the results of analyses of covariance comparing the knowledge test performance of trainers as a function of practice area. A statistically significant site difference was obtained for the first training day; $\underline{F}$ (1,51) = 4.20, $\underline{p}$ = .0456). Trainers who practiced in a rural area scored significantly lower on the post-training test (after controlling for pre-training differences) than those who practiced in an urban area. Rural practitioners answered two-thirds of the post-training test items correctly on the average, while urban practitioners scored correctly on approximately three-quarters of the knowledge test items. No difference in performance was noted for the second training day ($\underline{p} > .05$). Both rural and urban practitioners answered two-thirds to three-quarters of the items correctly on the average.

Area of Discipline Comparison of Knowledge Gains

Trainers were categorized on the basis of their discipline and compared for differences in knowledge gains. Nurses were compared with social workers and a mixed group of trainers in other disciplines. No significant differences in knowledge test performance were found for either training day.

Gender Comparison of Knowledge Gains

No significant differences between males and females were found in knowledge test performance on either of the two training days.

Further Comparisons of Training Evaluations

Multivariate analyses of variance (MANOVAs) were performed in order to further investigate the extent to which the training experience was effective and useful to participants. The dependent variables employed in the MANOVAs included responses to questions regarding: 1) quality of program materials, 2) program usefulness, 3) the extent to which the program broadened participants' knowledge base, 4) the extent to which the program helped trainers with their problem-solving techniques, 5) the extent to which the program would have a direct effect on the participant's practice, 6) the extent to which the program affected participant's view of caregiver quality of life, 7) content effectiveness, and 8) speaker effectiveness. Analyses examined responses for each training day separately, and for both days combined (using two-day mean scores as the dependent variables).

Site Category Comparisons of Training

Table 15 summarizes the statistically significant MANOVA results comparing the evaluation of participants attending either the urban, rural, or mixed site for the first day of training (Day A). The approximated F test indicated overall statistically significant site category differences in perception of the training [p < .05; Pillai's Trace = 0.51). An examination of univariate analyses of variance (ANOVAs) and Student-Newman-Keuls post-hoc comparisons revealed that participants attending the rural training site: 1) felt that the training broadened their knowledge base to a greater extent than did participants at either the urban and mixed sites [F (2,49) = 4.44, p = .0168]; 2) believed that the program provided more help with their problem-solving techniques than did trainers at the mixed site [F (2,49) = 4.06, p = .0233]; 3) regarded the training content as more effective than those at the mixed training site [F (2,49) = 6.25, p =.0038]; and 4) judged the speakers as more effective than those at either the urban or mixed training site [F (2,49) = 7.18, p = .0018].

Table 16 summarizes the statistically significant MANOVA results comparing the evaluation of participants attending either the urban, rural, or mixed site for the second day of training (Day B). Although the approximated F test was not statistically significant (p > .05; Pillai's Trace = 0.51), an examination of univariate ANOVAs and Student-Newman-Keuls post-hoc comparisons revealed several site category differences in perception of the training. Participants attending the rural training site indicated that the quality of the program materials were significantly better than those at the mixed training site; F (2,42) = 3.74, p = .0319. In addition, those attending training at rural sites rated the content as more effective than trainers at either the urban or the mixed sites; F (2,42) = 4.66, p = .0149. Although the post-hoc range test was not indicative, participants attending different sites provided significantly different responses concerning the extent to which the training broadened their knowledge base; F (2,42) = 3.52, p = .0387. Trainers at the rural sites had higher average ratings for this evaluation item, while those at the urban site provided the lowest average rating.

Ethnic Group Comparisons of Training

Table 17 summarizes the statistically significant MANOVA results comparing the evaluation of the first day of training (Day A) for African American and Caucasian participants. Although the approximated F test was not statistically significant ($p > .05$; Pillai's Trace = 0.13), an examination of univariate analyses of variance (ANOVAs) revealed that African American and Caucasian participants differed significantly with regard to their assessment of two aspects of the training. African American trainers: 1) felt that the training broadened their knowledge base to a greater extent than did Caucasian participants [F (1,50) = 4.24, p = .0448] and 2) regarded the speakers as more effective than their Caucasian counterparts [F (1,50) = 4.24, p =.0447].

Table 18 summarizes the statistically significant MANOVA results comparing the evaluation of the second day of training (Day B) for African American and Caucasian participants. Although the approximated F test was not statistically significant ($p > .05$; Pillai's Trace = 0.28), an examination of univariate analyses of variance (ANOVAs) revealed that African American and Caucasian participants differed significantly with regard to their assessment of six out of the eight aspects of the training queried. As on the first training day, African American participants provided higher average ratings of the training then did Caucasian participants. In comparison with their Caucasian counterparts African American trainers: 1) felt that the training broadened their knowledge base to a greater extent [F (1,43) = 9.09, p = .0043]; 2) regarded the training as more useful to them personally [F (1,43) = 7.52, p = .0089]; 3) surmised that the training would have a greater direct effect on their practices [F (1,43) = 4.78, p = .0343]; 4) regarded the training content as more effective [F (1,43) = 8.57, p =.0055]; 5) judged the speakers as more effective [F (1,43) = 8.46, p = .0057], and 6) felt the program materials were of better quality [F (1,43) = 10.58, p = .0022].

Table 19 summarizes the statistically significant MANOVA results comparing the two-day average (Both Days A and B) evaluation of the training for African American and Caucasian participants. The approximated F test approached statistical significance (p= .0828; Pillai's Trace = 0.34). An examination of univariate analyses of variance (ANOVAs) revealed that African American and Caucasian participants differed significantly with regard to their assessment of each of the eight aspects of the training queried. Consistent with the analyses of each training day separately, African American participants provided higher average ratings of the training then did Caucasian participants. In comparison with their Caucasian counterparts African American trainers: 1) felt that the training broadened their knowledge base to a greater extent [F (1,38) = 11.40, p = .0017]; 2) regarded the training as more useful to them personally [F (1,38) = 12.20, p = .0012]; 3) believed that the training would have a greater direct effect on their practices [F (1,38) = 4.71, p = .0363]; 4) believed that the program provided more help with their problem-solving techniques [F (1,38) = 6.76, p = .0132]; 5) affected their view of caregiver quality of life to a greater extent [F (1,38) = 6.50, p = .0149];

6) regarded the training content as more effective [$\underline{F}$ (1,38) = 11.59, $\underline{p}$ =.0016]; 7) judged the speakers as more effective [$\underline{F}$ (1,38) = 11.44, $\underline{p}$ = .0017]; and 8) felt the program materials were of better quality [$\underline{F}$ (1,38) = 11.75, $\underline{p}$ = .0015].

Education Group Comparisons of Training

A comparison of trainers with bachelor degrees, advanced degrees, and no four-year degrees (**Table 20**) revealed a statistically significant difference in their evaluation of the training content effectiveness for two-day average ratings ($\underline{p}$ < .05), although the ratings provided for each day separately did not reach significance ($\underline{p}$ > .05). Although the approximated $\underline{F}$ test was not statistically significant ($\underline{p}$ > .05; Pillai's Trace = 0.42), an examination of univariate ANOVAs and Student-Newman-Keuls post-hoc comparisons revealed that participants with bachelor degrees regarded the training content as more effective than either those with advanced degrees or those without four-year degrees [$\underline{F}$ (2,36) = 3.83, $\underline{p}$ = .0312].

Area of Work or Practice Comparisons of Training

There were no statistically significant differences between trainers who practiced in rural or urban areas with respect to their evaluation of the training.

Area of Discipline Comparisons of Training

A comparison of nurses, social workers, and those in other disciplines (**Table 21**) revealed a statistically significant difference in their evaluations of the program materials on the second training day only ($\underline{p}$ < .05). Although the approximated $\underline{F}$ test was not statistically significant ($\underline{p}$ > .05; Pillai's Trace = 0.33), an examination of univariate ANOVAs and Student-Newman-Keuls post-hoc comparisons revealed that nurses thought the training materials were of higher quality than either social workers or those in other disciplines [$\underline{F}$ (2,39) = 3.58, $\underline{p}$ = .0373].

Gender Comparisons of Training

Males and females did not differ significantly in terms of their evaluation of the training.

Summary

Trainers were predominantly African American and disproportionately female. The majority worked or practiced in a rural area. They tended to be well-educated, with almost half possessing advance degrees. Almost one-quarter were social workers, and more than one-quarter were nurses. The training was well-received, with high marks in all areas of evaluation.

Statistically significant gains in knowledge were demonstrated for both training days. An examination of knowledge gains by item indicated that participants performed better on the first training day than they did on the second training day. This difference was attributed to a greater reliance on guest lecturers on the second day of training. Item analyses revealed that only two of the items on the first-day knowledge test, and four of the items on the second-day knowledge test, were judged to have little discriminative ability. Internal reliabilities were acceptable, given the abbreviated length of the knowledge tests and the limited sample sizes employed.

Site comparisons of knowledge gains achieved indicated that the most remote, rural site performed least well. Participants at the urban site performed better on the second training day than trainers at the other sites. In general, rural participants failed to provide correct answers to about one-third of the post-training test items, while trainers at the urban and mixed sites scored correctly on three-quarters of the knowledge test items.

An examination of other comparisons of trainers resulting in statistically significant knowledge gain differences revealed that: 1) non-minority participants scored better than African American trainers, 2) trainers with four-year degrees out-performed those without degrees, and 3) urban practitioners showed greater knowledge gains than rural practitioners.

Several differences between trainers were noted with respect to their evaluation of the training. In general: 1) trainers at the rural sites provided higher ratings than those at the urban or mixed training sites, 2) African American trainees valued the training more highly than Caucasians, 3) participants with Bachelor degrees regarded the training content as more effective than those with advanced degrees or those without four-year degrees, and 4) nurses thought the training materials were of higher quality than either social workers or those in other disciplines.

TABLE 1. Demographic Characteristics of Training Participants (N=58)

Demographic Category	n	%
Day A Training Site		
Chester	13	22.8%
Lawrenceville	13	22.8%
Richmond	25	43.9%
South Boston	6	10.5%
Day B Training Site		
Chester	6	11.3%
Lawrenceville	15	28.3%
Richmond	26	49.1%
South Boston	6	11.3%
Ethnicity of Participants		
African American	38	65.5%
Caucasian	20	34.5%
Gender of Participants		
Male	10	17.2%
Female	48	82.8%
Area of Work or Practice		
Rural	36	64.3%
Urban	20	35.7%
Highest Level of Education		
Less than Bachelor Degree	14	24.5%
Bachelor Degree	16	28.1%
More than Bachelor Degree	27	47.4%
Discipline of Participant		
Nursing	17	31.5%
Social Work	13	24.1%
Other	24	44.4%

TABLE 1 (Cont'). Demographic Characteristics of Training Participants (N=58)

Demographic Category	n	%
Occupation		
Management	7	14.0%
Community Service Agency	5	10.0%
Nursing Home Staff	5	10.0%
Pastor/Minister	5	10.0%
Administrator	4	8.0%
Retired	4	8.0%
Clinical Nurse Specialist	3	6.0%
Hospital Staff	3	6.0%
Consulting	3	6.0%
Private Practice	2	4.0%
Academic Faculty	1	2.0%
Clinical Faculty	1	2.0%
Clinical Social Worker	1	2.0%
Student	1	2.0%
Social Worker	1	2.0%
Community Health Nurse	1	2.0%
Librarian	1	2.0%
Case Manager	1	2.0%
Activities Director	1	2.0%
Setting		
Community/Social Service Agency	9	16.1%
Retired/Not Seeking Employment, Not Actively Practicing	7	12.5%
Nursing Home	5	8.9%
College/University	4	7.1%
Home Health Agency	4	7.1%
Hospital	4	7.1%
Adult Day Care	3	5.4%
Federal Facility (military V.A., U.S.P.H.S.)	3	5.4%
Church	3	5.4%
Business/Industry	2	3.6%
Community Health Center	2	3.6%
Health Professional, College/University	2	3.6%
Mental Health Center	2	3.6%
Administrative or Regulatory Agency	1	1.8%
Freestanding Clinic, Ambulatory Care Center	1	1.8%
Institution for the Physically or Mentally Disabled	1	1.8%
Patient's/Client's Home	1	1.8%
Retreat Center	1	1.8%
Other Educational Institution	1	1.8%

TABLE 2. Results of Evaluation Questionnaire Completed By Training Participants (N=58)[*]

Evaluation Question	Day A	Day B	2-Day Average
Quality of Program Material			
Mean	4.41	4.35	4.36
Standard Deviation	0.65	0.67	0.56
N	56	46	44
Usefulness of Program			
Mean	4.55	4.39	4.43
Standard Deviation	0.54	0.61	0.49
N	56	46	44
Extent Program Broadened Knowledge Base			
Mean	4.13	4.39	4.25
Standard Deviation	0.76	0.74	0.68
N	56	46	44
Extent Program Improved Problem-Solving Ability			
Mean	3.84	4.22	4.03
Standard Deviation	0.74	0.70	0.63
N	55	46	43
Extent Program Will Directly Effect Practice			
Mean	4.30	4.30	4.30
Standard Deviation	0.74	0.63	0.61
N	56	46	44
Extent Program Affected View of Caregivers' QOL			
Mean	3.89	4.18	4.01
Standard Deviation	0.94	0.68	0.63
N	54	45	42
Overall Effectiveness of Training Content			
Mean	4.29	4.44	4.33
Standard Deviation	0.68	0.54	0.57
N	56	46	44
Overall Effectiveness of Trainers/Presenters			
Mean	4.38	4.50	4.42
Standard Deviation	0.65	0.55	0.52
N	55	46	43

[*] Items rated on 5-point Likert-type scale

TABLE 3. Results of Day A and Day B Pre-Training and Post-Training Knowledge Test Total Scores for All Training Participants

TRAINING DAY A (N=56)

Testing Time	Average % Score	Standard Deviation
Pre-Training	52.61%	14.28
Post-Training	71.15%	17.68

$t = 8.34$

$p = .0001$

TRAINING DAY B (N=50)

Testing Time	Average % Score	Standard Deviation
Pre-Training	64.86%	13.21
Post-Training	70.86%	14.78

$t = 3.43$

$p = .0012$

TABLE 4. Results of Day A and Day B Knowledge Test Total Scores for Participants Scoring Less than 65% on Pre-Training Test

TRAINING DAY A (N=45)

Testing Time	Average % Score	Standard Deviation
Pre-Training	47.18%	9.65
Post-Training	68.72%	18.51

_t_ = 8.53

_p_ = .0001

TRAINING DAY B (N=27)

Testing Time	Average % Score	Standard Deviation
Pre-Training	55.03%	8.12
Post-Training	63.76%	13.72

_t_ = 3.75

_p_ = .0009

TABLE 5. Results of Day A Pre-Training and Post-Training Knowledge Test Items (N=56)*

Knowledge Test Item	Pre %	Post %	t	p
1) Incidence of AD among elders 85 and older	35.7%	62.5%	3.25	.0020
2) The definition of dementia	83.9%	89.3%	1.00	.3217
3) The definition of Alzheimer's Disease	50.0%	71.4%	2.85	.0062
4) Most conclusive method of diagnosing AD	75.0%	91.1%	2.62	.0112
5) Conditions accompanying/related to AD	39.3%	75.0%	5.53	.0001
6) Primary symptom of AD in early stages	82.1%	91.1%	1.53	.1329
7) The nature of caregiver burden	87.5%	69.6%	-2.84	.0064
8) Appropriate way to teach adults	32.1%	76.8%	5.56	.0001
9) Learning difficulties among older adults	64.3%	87.5%	3.22	.0021
10) Curvilinear relation b/t caregiver burden and recipients' level of cognitive functioning	8.9%	33.9%	3.92	.0002
11) Independent relation between caregiver burden and support group participation	19.6%	66.1%	6.46	.0001
12) Benefits of reinforcing support group participation with community services	94.6%	92.9%	-0.44	.6588
13) Independent relation between objective and perceived caregiver burden	10.7%	17.9%	1.27	.2088

* Percentages refer to proportion of participants answering item correctly

TABLE 6. Results of Day B Pre-Training and Post-Training Knowledge Test Items (N=50)*

Knowledge Test Item	Pre %	Post %	t	p
1) Barriers to minority service utilization	58.0%	70.0%	1.77	.0832
2) Under-diagnosis of dementia in rural areas	86.0%	94.0%	1.66	.1030
3) Extended-family caregivers in African American communities	6.0%	8.0%	0.37	.7095
4) Barriers to rural service utilization	76.0%	72.0%	-0.62	.5325
5) Greatest need for information and services among rural, African Americans	88.0%	90.0%	0.57	.5690
6) Relative proportion of population that is elderly in metropolitan/non-metropolitan areas	60.0%	64.0%	0.42	.6742
7) Participation in AD support groups among urban versus rural caregivers	34.0%	32.0%	-0.28	.7846
8) Precipitants of nursing home placement among African American caregivers	14.0%	56.0%	5.96	.0001
9) Higher prevalence of dementia among African Americans	90.0%	96.0%	1.35	.1824
10) Under-utilization of community mental health services by rural elderly	66.0%	68.0%	0.30	.7664
11) Post-figurative values in rural communities	88.0%	92.0%	1.43	.1594
12) Greater functional impairment among African American nursing home residents	70.0%	62.0%	-1.00	.3222
13) Equal levels of burden reported by African American and Caucasian caregivers	88.0%	90.0%	0.33	.7425
14) Greater reliance on prayer and religion among African American caregivers	84.0%	98.0%	2.82	.0068

* Percentages refer to proportion of participants answering item correctly

TABLE 7. Item Analysis for Day A Pre-Training and Post-Training Knowledge Test (N=56)*

Knowledge Test Item	Low	Moderate	High
1) Incidence of AD among elders 85 and older	23.1%	65.4%	88.2%
2) The definition of dementia	69.2%	92.3%	100.0%
3) The definition of Alzheimer's Disease	23.1%	80.8%	94.1%
4) Most conclusive method of diagnosing AD	69.2%	96.2%	100.0%
5) Conditions accompanying and related to AD	38.5%	80.8%	94.1%
6) Primary symptom of AD in early stages	69.2%	96.2%	100.0%
7) The nature of caregiver burden	15.4%	76.9%	100.0%
8) Appropriate way to teach adults	46.2%	84.6%	88.2%
9) Learning difficulties among older adults	61.5%	92.3%	100.0%
10) Curvilinear relation between caregiver burden and recipients level of cognitive functioning	38.5%	15.4%	58.8%
11) Independent relation between caregiver burden and support group participation	46.2%	65.4%	82.4%
12) Benefits of reinforcing support group participation with community services	76.9%	100.0%	94.1%
13) Independent relation between objective and perceived caregiver burden	7.7%	3.8%	47.1%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 8. Item Analysis for Day B Pre-Training and Post-Training Knowledge Test (N=50)*

Knowledge Test Item	Low	Moderate	High
1) Barriers to minority service utilization	27.3%	77.8%	91.7%
2) Under-diagnosis of dementia in rural areas	81.8%	96.3%	100.0%
3) Extended-family caregivers in African American communities	9.1%	3.7%	16.7%
4) Barriers to rural service utilization	27.3%	77.8%	100.0%
5) Greatest need for information and services among rural, African Americans	72.7%	92.6%	100.0%
6) Relative proportion of population that is elderly in metropolitan/non-metropolitan areas	36.4%	63.0%	91.7%
7) Participation in AD support groups among urban versus rural caregivers	9.1%	18.5%	83.3%
8) Precipitants of nursing home placement among African American caregivers	18.2%	51.9%	100.0%
9) Higher prevalence of dementia among African Americans	90.9%	96.3%	100.0%
10) Under-utilization of community mental health services by rural elderly	45.5%	66.7%	91.7%
11) Post-figurative values in rural communities	72.7%	96.3%	100.0%
12) Greater functional impairment among African American nursing home residents	45.5%	59.3%	83.3%
13) Equal levels of burden reported by African American and Caucasian caregivers	63.6%	96.3%	100.0%
14) Greater reliance on prayer and religion among African American caregivers	100.0%	100.0%	91.7%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 9. Results of Day A and Day B Pre-Training and Post-Training Knowledge Test Total Scores by Training Site

TRAINING DAY A (N=56)

Training Site	Average % Score	Standard Deviation	t	p
Chester (n=12)				
Pre-Training	60.26%	13.05		
Post-Training	81.41%	10.09	5.40	.0002
Richmond (n=25)				
Pre-Training	51.08%	14.02		
Post-Training	73.85%	15.54	6.82	.0001
Lawrenceville (n=13)				
Pre-Training	53.25%	15.53		
Post-Training	68.05%	16.87	3.51	.0043
South Boston (n=6)				
Pre-Training	42.31%	8.07		
Post-Training	46.15%	17.54	0.50	.6355

TRAINING DAY B (N=50)

Training Site	Average % Score	Standard Deviation	t	p
Chester (n=6)				
Pre-Training	70.24%	12.30		
Post-Training	71.43%	12.78	0.21	.8417
Richmond (n=25)				
Pre-Training	66.86%	13.34		
Post-Training	76.00%	13.18	3.72	.0011
Lawrenceville (n=15)				
Pre-Training	63.81%	10.96		
Post-Training	68.57%	13.17	1.50	.1551
South Boston (n=4)				
Pre-Training	48.21%	12.20		
Post-Training	46.43%	7.14	-0.52	.6376

TABLE 10. Results of Four Site Comparision for Day A and Day B Analyses of Covariance on Knowledge Test Scores

TRAINING DAY A (N=56)

Training Site	Least Squares Mean	Standard Error LSMean
Chester (n=12)	78.12%	4.19
Richmond (n=25)	74.51%	2.82
Lawrenceville (n=13)	67.77%	3.89
South Boston (n=6)	50.59%*	5.91

MODEL F (4,51) = 9.06; p = .0001
SITE F (3, 51) = 5.54; p = .0023

TRAINING DAY B (N=50)

Training Site	Least Squares Mean	Standard Error LSMean
Chester (n=6)	68.46%	4.52
Richmond (n=25)	74.90%	2.20
Lawrenceville (n=15)	69.15%	2.83
South Boston (n=4)	55.60%*	5.88

MODEL F (4, 45) = 11.06; p = .0001
SITE F (3, 45) = 3.50; p = .0230

*Average Total Score differs significantly from others

TABLE 11. Results of Site Category Comparision for Day A and Day B Analyses of Covariance on Knowledge Test Scores

TRAINING DAY A (N=56)

Training Site	Least Squares Mean	Standard Error LSMean
Mixed (n=12)	77.73%	4.12
Urban (n=25)	74.63%	2.90
Rural (n=13)	61.58%*	3.43

MODEL *F* (3,52) = 10.04; *p* = .0001
SITE CATEGORY *F* (2, 52) = 5.84; *p* = .0052

TRAINING DAY B (N=50)

Training Site	Least Squares Mean	Standard Error LSMean
Mixed (n=12)	71.92%	3.15
Urban (n=25)	74.93%	2.44
Rural (n=13)	64.67%*	2.96

MODEL *F* (3,45) = 13.37; *p* = .0001
SITE CATEGORY *F* (2, 45) = 3.56; *p* = .0367

*Average Total Score differs significantly from others

TABLE 12. Results of Ethnic Group Comparision for Day A and Day B Analyses of Covariance on Knowledge Test Scores

TRAINING DAY A (N=56)

Training Site	Least Squares Mean	Standard Error LSMean
Caucasian (n=20)	78.25%	3.67
African American (n=36)	67.21%	2.64

MODEL F (2,53) = 11.13; p = .0001
SITE CATEGORY F (1, 53) = 5.35; p = .0247

TRAINING DAY B (N=50)

Training Site	Least Squares Mean	Standard Error LSMean
Caucasian (n=17)	75.76%	2.84
African American (n=33)	68.33%	2.01

MODEL F (2,47) = 17.81; p = .0001
SITE CATEGORY F (1, 47) = 4.37; p = .0421

TABLE 13. Results of Education Category Comparision for Day A and Day B Analyses of Covariance on Knowledge Test

TRAINING DAY A (N=56)

Training Site	Least Squares Mean	Standard Error LSMean
More Than Bachelor Degree (n=25)	75.97%	2.95
Bachelor Degree (n=16)	75.98%	3.50
Less Than Bachelor Degree (n=14)	59.92%*	4.00

MODEL *F* (3,51) = 9.45; *p* = .0001
SITE CATEGORY *F* (2, 51) = 5.82; *p* = .0053

TRAINING DAY B (N=50)

Training Site	Least Squares Mean	Standard Error LSMean
More Than Bachelor Degree (n=24)	72.84%	2.31
Bachelor Degree (n=14)	76.08%	2.95
Less Than Bachelor Degree (n=11)	62.44%*	3.55

MODEL *F* (3,45) = 12.06; *p* = .0001
SITE CATEGORY *F* (2, 45) = 4.48; *p* = .0168

*Average Total Score differs significantly from others

TABLE 14. Results of Area of Work or Practice Comparision for Day A and Day B Analyses of Covariance on Knowledge Test

TRAINING DAY A (N=56)

Training Site	Least Squares Mean	Standard Error LSMean
Urban (n=20)	77.06%	3.41
Rural (n=34)	68.24%	2.62

MODEL *F* (2,51) = 10.00; *p* = .0002
SITE CATEGORY *F* (1, 51) = 4.20; *p* = .0456

TRAINING DAY B (N=50)

Training Site	Least Squares Mean	Standard Error LSMean
Urban (n=17)	72.49%	2.89
Rural (n=33)	70.02%	2.07

MODEL *F* (2,47) = 14.68; *p* = .0001
SITE CATEGORY *F* (1, 47) = 0.48; *p* = .4926

TABLE 15. Results of Statistically Significant Site Category Comparisions for Day A Multivariate Analyses of Variance on Evaluation Questions (N=58)

Training Site	Mean	Std. Dev.	F	df	p
Broadened Knowledge					
Rural (n=18)	4.50*	0.51			
Urban (n=21)	4.00	0.78			
Mixed (n=13)	3.77	0.83	4.44	2,49	.0168
Problem-Solving Help					
Rural (n=18)	4.17**	0.62			
Urban (n=21)	3.76	0.77			
Mixed (n=13)	3.46**	0.66	4.06	2,49	.0233
Content Effectiveness					
Rural (n=18)	4.67**	0.49			
Urban (n=21)	4.28	0.72			
Mixed (n=13)	3.85**	0.69	6.25	2,49	.0038
Speaker Effectiveness					
Rural (n=18)	4.83*	0.38			
Urban (n=21)	4.24	0.70			
Mixed (n=13)	4.15	0.55	7.18	2,49	.0018

Pillai's Trace = 0.51; Approximated F (16,82) = 1.84; p = .0381

*Mean value differs significantly from all others in group

**Mean values indicated are significantly different from each other (Extreme values are significantlly different)

TABLE 16. Results of Statistically Significant Site Category Comparisions for Day B Multivariate Analyses of Variance on Evaluation Questions (N=58)

Training Site	Mean	Std. Dev.	F	df	p
Quality of Materials					
Rural (n=18)	4.67**	0.59			
Urban (n=21)	4.19	0.68			
Mixed (n=6)	4.00**	0.63	3.74	2,42	.0319
Broadened Knowledge					
Rural (n=18)	4.72	0.46			
Urban (n=21)	4.14	0.85			
Mixed (n=6)	4.50	0.55	3.52	2,42	.0387
Content Effectiveness					
Rural (n=18)	4.72*	0.46			
Urban (n=21)	4.29	0.56			
Mixed (n=6)	4.17	0.41	4.66	2,42	.0149

Pillai's Trace = 0.51; Approximated F (16,72) = 1.53; p = .1138

*Mean value differs significantly from all others in group

**Mean values indicated are significantly different from each other (Extreme values are significantlly different)

TABLE 17. Results of Statistically Significant Ethnic Comparisions for Day A Multivariate Analyses of Variance on Evaluation Questions (N=58)

Ethnic Group	Mean	Std. Dev.	F	df	p
Broadened Knowledge					
African American (n=32)	4.28	0.68			
Caucasian (n=20)	3.85	0.81	4.24	1,50	.0448
Speaker Effectiveness					
African American (n=32)	4.56	0.56			
Caucasian (n=20)	4.20	0.70	4.24	1,50	.0447

Pillai's Trace = 0.13; Approximated F (8,43) = 0.80; p = .6061

TABLE 18. Results of Statistically Significant Ethnic Comparisions for Day B Multivariate Analyses of Variance on Evaluation Questions (N=58)

Ethnic Group	Mean	Std. Dev.	F	df	p
Quality of Materials					
African American (n=32)	4.56	0.57			
Caucasian (n=20)	3.93	0.70	10.58	1,43	.0022
Usefulness of Program					
African American (n=32)	4.56	0.50			
Caucasian (n=20)	4.07	0.70	7.52	1,43	.0089
Broadened Knowledge					
African American (n=32)	4.63	0.56			
Caucasian (n=20)	4.00	0.84	9.09	1,43	.0043
Effect on Practices					
African American (n=32)	4.47	0.51			
Caucasian (n=20)	4.07	0.70	4.78	1,43	.0343
Content Effectiveness					
African American (n=32)	4.60	0.50			
Caucasian (n=20)	4.13	0.52	8.57	1,43	.0055
Speaker Effectiveness					
African American (n=32)	4.67	0.48			
Caucasian (n=20)	4.20	0.56	8.46	1,43	.0057

Pillai's Trace = 0.28; Approximated F (8,36) = 1.79; p = .1121

TABLE 19. Results of Statistically Significant Ethnic Comparisions for Two-Day Average Multivariate Analyses of Variance on Evaluation Questions (N=58)

Ethnic Group	Mean	Std. Dev.	F	df	p
Quality of Materials					
African American (n=32)	4.60	0.43			
Caucasian (n=20)	4.03	0.61	11.75	1,38	.0015
Usefulness of Program					
African American (n=32)	4.64	0.37			
Caucasian (n=20)	4.13	0.55	12.20	1,38	.0012
Broadened Knowledge					
African American (n=32)	4.48	0.49			
Caucasian (n=20)	3.83	0.72	11.40	1,38	.0017
Problem-Solving Help					
African American (n=32)	4.22	0.56			
Caucasian (n=20)	3.73	0.59	6.76	1,38	.0132
Effect on Practices					
African American (n=32)	4.50	0.48			
Caucasian (n=20)	4.10	0.69	4.71	1,38	.0363
View of Caregiver QOL					
African American (n=32)	4.22	0.56			
Caucasian (n=20)	3.73	0.57	6.50	1,38	.0149
Content Effectiveness					
African American (n=32)	4.58	0.49			
Caucasian (n=20)	4.00	0.57	11.59	1,38	.0016
Speaker Effectiveness					
African American (n=32)	4.64	0.40			
Caucasian (n=20)	4.13	0.55	11.44	1,38	.0017

Pillai's Trace = 0.34; Approximated F (8,31) = 1.98; p = .0828

TABLE 20. Results of Statistically Significant Education Category Comparisions for Two-Day Average Multivariate Analyses of Variance on Evaluation Questions (N=58)

Education Category	Mean	Std. Dev.	F	df	p
Content Effectiveness					
< Bachelor Degree (n=9)	4.77*	0.36			
Bachelor Degree (n=12)	4.29	0.66			
> Bachelor Degree (n=18)	4.17	0.54	3.83	2,36	.0312

Pillai's Trace = 0.42; Approximated F (16,60) = 0.99; p = .4782

*Mean value differs significantly from all others in group

TABLE 21. Results of Statistically Significant Discipline Category Comparisions for Day B Multivariate Analyses of Variance on Evaluation Questions (N=58)

Discipline Category	Mean	Std. Dev.	F	df	p
Quality of Materials					
Nursing (n=14)	4.71*	0.47			
Social Work (n=9)	4.11	0.60			
Other (n=19)	4.21	0.71	3.58	2,39	.0373

Pillai's Trace = 0.33; Approximated F (16,66) = 0.82; p = .6540

*Mean value differs significantly from all others in group

APPENDIX V-A

EVALUATION QUESTIONNAIRE
PRE-TEST FOR DAY A TRAINING

Trainer Identification Number ______________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Among individuals age 85 and older, the incidence of Alzheimer's Disease is almost:
   a. 10%.
   b. 35%.
   c. 75%.
   d. 50%.

2. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

3. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

4. The most conclusive method of diagnosing Alzheimer's Disease:
   a. is accomplished through a CAT scan.
   b. is based on the results of IQ tests.
   c. can be made only upon examination of brain tissue at autopsy.

5. All of the following may be accompanied by dementia and are related to Alzheimer's Disease, except:
   a. hardening of the arteries.
   b. Parkinson's disease.
   c. depression.
   d. Huntington's disease.

6. ________________ is the primary symptom of Alzheimer's Disease in the early stages.
   a. Visual and/or auditory hallucinations
   b. Forgetfulness
   c. Wandering
   d. Long term memory loss

7. Caregiver burden:
   a. impairs the caregiver's ability to provide care.
   b. can increase the probability that a patient will need to be placed in a nursing home prematurely.
   c. can be decreased by support from the caregiver's family and friends.
   d. all of the above.

8. ____________________ is the appropriate way to teach children, while ____________ is the best way to teach adults.
   a. Andragogy, pedagogy
   b. Pedagogy, andragogy
   c. Telegogy, envirogogy
   d. Envirogogy, telegogy

9. Older adult learners may have difficulty learning because of:
   a. medications.
   b. presbyopia.
   c. presbycusis.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 10. There is a direct relation between caregiver burden or strain and the care recipient's level of cognitive impairment, with burden peaking in the later stages when the patient's intellectual ability is worst.

_____ 11. Support group participation per se does not result in significant decreases in caregiver burden or depression.

_____ 12. Support group participation is most beneficial when it is reinforced with appropriate community services.

_____ 13. The amount of stress reported by caregivers (i.e., perceived burden) is directly related to their caregiving responsibilities (i.e., objective burden), with greater burden being associated with greater responsibility.

EVALUATION QUESTIONNAIRE
POST-TEST FOR DAY A TRAINING

Trainer Identification Number ______________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Among individuals age 85 and older, the incidence of Alzheimer's Disease is almost:
   a. 10%.
   b. 35%.
   c. 75%.
   d. 50%.

2. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

3. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

4. The most conclusive method of diagnosing Alzheimer's Disease:
   a. is accomplished through a CAT scan.
   b. is based on the results of IQ tests.
   c. can be made only upon examination of brain tissue at autopsy.

5. All of the following may be accompanied by dementia and are related to Alzheimer's Disease, except:
   a. hardening of the arteries.
   b. Parkinson's disease.
   c. depression.
   d. Huntington's disease.

6. ________________ is the primary symptom of Alzheimer's Disease in the early stages.
   a. Visual and/or auditory hallucinations
   b. Forgetfulness
   c. Wandering
   d. Long term memory loss

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   a. impairs the caregiver's ability to provide care.
   b. can increase the probability that a patient will need to be placed in a nursing home prematurely.
   c. can be decreased by support from the caregiver's family and friends.
   d. all of the above.

8. ____________________ is the appropriate way to teach children, while ____________ is the best way to teach adults.
   a. Andragogy, pedagogy
   b. Pedagogy, andragogy
   c. Telegogy, envirogogy
   d. Envirogogy, telegogy

9. Older adult learners may have difficulty learning because of:
   a. medications.
   b. presbyopia.
   c. presbycusis.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

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_____ 11. Support group participation per se does not result in significant decreases in caregiver burden or depression.

_____ 12. Support group participation is most beneficial when it is reinforced with appropriate community services.

_____ 13. The amount of stress reported by caregivers (i.e., perceived burden) is directly related to their caregiving responsibilities (i.e., objective burden), with greater burden being associated with greater responsibility.

EVALUATION QUESTIONNAIRE
PRE-TEST FOR DAY B TRAINING

Trainer Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's Disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. In rural areas dementia is probably:
   a. under-diagnosed.
   b. over-diagnosed.
   c. more prevalent than in urban areas.
   d. less prevalent than in urban areas.

3. African American elders are ____________ to be cared for exclusively by primary (blood-related) family members.
   a. less likely
   b. more likely
   c. equally likely

4. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

5. The need for information and services may be highest among____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

6. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

7. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from _________________ than those in rural areas.
   a. caregiver support groups
   b. ministers
   c. friends and neighbors
   d. all of the above

8. Among African American caregivers of relatives with Alzheimer's Disease, the decision to make a nursing home placement is most often due to:
   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 9. There may be a higher prevalence of dementia among African Americans due to an increased risk of stroke due to high blood pressure.

_____ 10. The rural elderly account for the majority of community mental health patients.

_____ 11. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 12. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 13. African American caregivers experience less caregiver burden or stress than white caregivers.

_____ 14. African American caregivers of family members with Alzheimer's Disease rely more on prayer and religion than white caregivers as a means of coping.

EVALUATION QUESTIONNAIRE
POST-TEST FOR DAY B TRAINING

Trainer Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. In rural areas dementia is probably:
   a. under-diagnosed.
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   c. more prevalent than in urban areas.
   d. less prevalent than in urban areas.

3. African American elders are ______________ to be cared for exclusively by primary (blood-related) family members.
   a. less likely
   b. more likely
   c. equally likely

4. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

5. The need for information and services may be highest among____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

6. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

7. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from ________________ than those in rural areas.
   a. caregiver support groups
   b. ministers
   c. friends and neighbors
   d. all of the above

8. Among African American caregivers of relatives with Alzheimer's Disease, the decision to make a nursing home placement is most often due to:
   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 9. There may be a higher prevalence of dementia among African Americans due to an increased risk of stroke due to high blood pressure.

_____ 10. The rural elderly account for the majority of community mental health patients.

_____ 11. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 12. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 13. African American caregivers experience less caregiver burden or stress than white caregivers.

_____ 14. African American caregivers of family members with Alzheimer's Disease rely more on prayer and religion than white caregivers as a means of coping.

VIRGINIA CENTER ON AGING TRAINING EVALUATION - DAY A

Trainer Identification Number: ______________________________

I. PARTICIPANT BACKGROUND

Please fill in your numerical response to the right of each question. For sections A through E, select the corresponding number from the attached code sheet.

A. Race/Ethnicity ____

B. Highest Level of Education ____

C. Discipline ____

D. Occupation ____

E. Practice Setting ____

F. Area of Work or Practice ____
1. Rural
2. Urban

G. Gender ____
1. Female
2. Male

H. Approximate percentage of your workshop participants who will be aged 60 or above ____

I. Approximate percentage of your workshop participants who will be members of ethnic minority groups ____

J. Approximate percentage of your older workshop participants who will be from rural areas ____

K. Approximate percentage of your total workshop participants who will be aged 60+ and:
1. Female ____
2. Male ____

Circle the appropriate number with 1 representing "not at all" and 5 representing "to a great extent."

LOW HIGH

A. To what extent have your expectations been met?

1. Quality of program material (audio-visuals and handouts)
1 2 3 4 5

2. Usefulness of this program to you
1 2 3 4 5

B. 1. To what extent did the program broaden your knowledge base?
1 2 3 4 5

2. To what extent did the program help you with problem-solving techniques?
1 2 3 4 5

3. To what extent do you foresee that this program will have a direct effect on your practices?
1 2 3 4 5

4. To what extent did this program affect your view of your participants' quality of life?
1 2 3 4 5

C. How would you rate the overall effective of this training?

1. Overall effectiveness of the training content
1 2 3 4 5

2. Overall effectiveness of the trainers/presenters
1 2 3 4 5

D. 1. What were the most helpful aspects of this training?

2. What were the least helpful aspects of this training?

E. 1. Were there relevant topics not covered in this training (please specify)?
[ ] yes [ ] no

2. Please identify those topics which were not covered from those listed on the attached code sheet (II-E Most Vital Topics) and list the corresponding code numbers below.

VIRGINIA CENTER ON AGING TRAINING EVALUATION - DAY B

Trainer Identification Number: ______________________________

I. PARTICIPANT BACKGROUND

Please fill in your numerical response to the right of each question. For sections A through E, select the corresponding number from the attached code sheet.

A. Race/Ethnicity ____

B. Highest Level of Education ____

C. Discipline ____

D. Occupation ____

E. Practice Setting ____

F. Area of Work or Practice ____
  1. Rural
  2. Urban

G. Gender ____
  1. Female 2. Male

H. Approximate percentage of your workshop participants who will be aged 60 or above ____

I. Approximate percentage of your workshop participants who will be members of ethnic minority groups ____

J. Approximate percentage of your older workshop participants who will be from rural areas ____

K. Approximate percentage of your total workshop participants who will be aged 60+ and:
  1. Female ____
  2. Male ____

Circle the appropriate number with 1 representing "not at all" and 5 representing "to a great extent."

LOW HIGH

A. To what extent have your expectations been met?

1. Quality of program material (audio-visuals and handouts)
   1 2 3 4 5

2. Usefulness of this program to you
   1 2 3 4 5

B. 1. To what extent did the program broaden your knowledge base?
   1 2 3 4 5

2. To what extent did the program help you with problem-solving techniques?
   1 2 3 4 5

3. To what extent do you foresee that this program will have a direct effect on your practices?
   1 2 3 4 5

4. To what extent did this program affect your view of your participants' quality of life?
   1 2 3 4 5

C. How would you rate the overall effective of this training?

1. Overall effectiveness of the training content
   1 2 3 4 5

2. Overall effectiveness of the trainers/presenters
   1 2 3 4 5

D. 1. What were the most helpful aspects of this training?

____

____

2. What were the least helpful aspects of this training?

____

____

E. 1. Were there relevant topics not covered in this training (please specify)?
   [ ] yes [ ] no

2. Please identify those topics which were not covered from those listed on the attached code sheet (II-E Most Vital Topics) and list the corresponding code numbers below.

____

____

CODE SHEET

I-A. Race/Ethnicity

100	African American
101	Asian American/Pacific Islander
102	Caucasian
103	Hispanic, any race
104	Native American/Alaskan Native
105	Other (specify)

I-B. Highest Level of Education

200	High School
201	A.A./A.A.S.
202	B.A.
203	B.S.
204	B.S.N.
205	B.S.W.
206	D.D.S.
207	D.M.D.
208	D.O.
209	D.P.A.
210	D.P.M.
211	D.S.W.
212	Ed.D.
213	L.P.N.
214	M.A.
215	M.B.A.
216	M.D.
217	M.Ed.
218	M.P.A.
219	M.P.H.
220	M.S.
221	M.S. in Gerontology
222	M.S.N.
223	M.S.S.W.
224	M.S.W.
225	Pharm.D.
226	Ph.D.
227	R.N.
228	SCI.D.
229	Other (specify)

I-C. Discipline

300	Audiology
301	Counseling
302	Dental Hygiene
303	Dentistry
304	Dietetics
305	Family Practice
306	Geriatric Medicine
307	Gerontology
308	Health Care Administration
309	Health Education
310	Internal Medicine
311	Medicine
312	Nursing
313	Occupational Therapy
314	Ophthalmology
315	Osteopathic Medicine
316	Pharmacy
317	Physical Therapy
318	Physician Assistant
319	Podiatry
320	Psychiatry
321	Psychology
322	Public Health
323	Recreational Therapy
324	Rehabilitation Counseling
325	Rehabilitation Medicine
326	Respiratory Therapy
327	Social Work
328	Speech Pathology
329	Other (specify)

I-D. Occupation

400	Academic Faculty
401	Administrator
402	Clinical Faculty
403	Clinical Nurse Specialist
404	Clinical Social Worker
405	Community Service Agency
406	Fellow/Resident
407	Hospital Staff
408	In-service/Continuing Education
409	Instructor
410	Management
411	Nurse Practitioner
412	Nursing Home Staff
413	Private Practice/Community-based Practice
414	Student
415	Other (specify)

I-E. Practice Setting

500	Administrative or Regulatory Agency
501	Adult Day Care
502	Business/Industry
503	College/University, Non-health Related
504	Community Health Center
505	Community/Social Service

	Agency
506	Federal Facility (military V.A., U.S.P.H.S.)
507	Freestanding Clinic, Ambulatory Care Center
508	Health Professional, College/University
509	Home Health Agency
510	Hospital
511	Institution for the Physically or Mentally Disabled
512	Local Public Health Unit
513	Medical Research Institution
514	Mental Health Center
515	Military Health Facility
516	Nursing Home
517	Other Long-term Care Facility
518	Patient's/Client's Home
519	Practitioner's Office (solo, partnership or group)
520	Professional or Allied Health Association
521	Temporary Employment Agency
522	Retired/Unemployed, Not Seeking Employment, Not Actively Practicing
523	Other (specify)

II-E. Most Vital Topics

600	Adult Day Health Care
601	Alzheimer's Disease
602	Arthritis
603	Autonomy
604	Cancer
605	Cardiovascular Diseases
606	Case Management
607	Cerebrovascular Diseases
608	Community-based Care
609	Comprehensive Geriatric Assessment
610	Confusional States
611	Crime
612	Death, Dying, Bereavement
613	Depression
614	Developmental Disabilities
615	Diabetes
616	Discharge Planning and Continuity of Care
617	Elder Abuse
618	Emergency Care
619	Falls
620	Family Dynamics/Caregiving
621	Financing Aging Problems
622	Functional Assessment
623	Geriatric Evaluation Units
624	Geriatric Rehabilitation
625	Geropharmacy
626	Health Care Financing/Reimbursement Issues
627	Health Promotion and Fitness
628	Health Screening
629	HIV Infection
630	Hospice Services
631	Hospital-based Home Care
632	Hypertension
633	Iatrogenesis
634	Incontinence
635	Infection Control
636	Infectious Diseases
637	Institutional Long-Term Care
638	Loneliness
639	Mental Illness
640	Minority Elder
641	Mobility/Ambulation
642	Model Programs
643	Multidisciplinary Team Care
644	Nutritional Deficiencies
645	Oral Health Problems
646	Osteoporosis
647	Outpatient Services
648	Parkinson's Disease
649	Patient Education and Counseling
650	Polypharmacy
651	Psychotherapies
652	Pulmonary Disease
653	Quality Assurance
654	Recreation/Educational Activities
655	Religion and Aging
656	Respite Care
657	Rural Elderly
658	Safety and Accident Prevention
659	Self Care Management
660	Sensory Impairment
661	Sexuality
662	Skin Breakdown
663	Sleep Disorders
664	Staffing Issues
665	Substance Abuse
666	Suicide
667	Surgery with Older Patients
668	Transportation
669	Women's Issues
670	Other (specify)

APPENDIX V-B

EVALUATION QUESTIONNAIRE
PRE-TEST FOR DAY A TRAINING

Trainer Identification Number ____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Among individuals age 85 and older, the incidence of Alzheimer's Disease is almost:
   a. 10%.
   b. 35%.
   c. 75%.
   d. 50%.

2. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

3. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

4. The most conclusive method of diagnosing Alzheimer's Disease:
   a. is accomplished through a CAT scan.
   b. is based on the results of IQ tests.
   c. can be made only upon examination of brain tissue at autopsy.

5. All of the following may be accompanied by dementia and are related to Alzheimer's Disease, except:
   a. hardening of the arteries.
   b. Parkinson's disease.
   c. depression.
   d. Huntington's disease.

6. ____________________ is the primary symptom of Alzheimer's Disease in the early stages.
   a. Visual and/or auditory hallucinations
   b. Forgetfulness
   c. Wandering
   d. Long term memory loss

7. Caregiver burden:
   a. impairs the caregiver's ability to provide care.
   b. can increase the probability that a patient will need to be placed in a nursing home prematurely.
   c. can be decreased by support from the caregiver's family and friends.
   d. all of the above.

8. ________________________ is the appropriate way to teach children, while ______________ is the best way to teach adults.
   a. Andragogy, pedagogy
   b. Pedagogy, andragogy
   c. Telegogy, envirogogy
   d. Envirogogy, telegogy

9. Older adult learners may have difficulty learning because of:
   a. medications.
   b. presbyopia.
   c. presbycusis.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 10. Support group participation per se does not result in significant decreases in caregiver burden or depression.

_____ 11. Support group participation is most beneficial when it is reinforced with appropriate community services.

EVALUATION QUESTIONNAIRE
POST-TEST FOR DAY A TRAINING

Trainer Identification Number ________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Among individuals age 85 and older, the incidence of Alzheimer's Disease is almost:
   a. 10%.
   b. 35%.
   c. 75%.
   d. 50%.

2. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

3. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

4. The most conclusive method of diagnosing Alzheimer's Disease:
   a. is accomplished through a CAT scan.
   b. is based on the results of IQ tests.
   c. can be made only upon examination of brain tissue at autopsy.

5. All of the following may be accompanied by dementia and are related to Alzheimer's Disease, except:
   a. hardening of the arteries.
   b. Parkinson's disease.
   c. depression.
   d. Huntington's disease.

6. ________________ is the primary symptom of Alzheimer's Disease in the early stages.

a. Visual and/or auditory hallucinations
b. Forgetfulness
c. Wandering
d. Long term memory loss

7. Caregiver burden:

a. impairs the caregiver's ability to provide care.
b. can increase the probability that a patient will need to be placed in a nursing home prematurely.
c. can be decreased by support from the caregiver's family and friends.
d. all of the above.

8. ____________________ is the appropriate way to teach children, while ____________ is the best way to teach adults.

a. Andragogy, pedagogy
b Pedagogy, andragogy
c. Telegogy, envirogogy
d. Envirogogy, telegogy

9. Older adult learners may have difficulty learning because of:

a. medications.
b. presbyopia.
c. presbycusis.
d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 10. Support group participation per se does not result in significant decreases in caregiver burden or depression.

_____ 11. Support group participation is most beneficial when it is reinforced with appropriate community services.

EVALUATION QUESTIONNAIRE
PRE-TEST FOR DAY B TRAINING

Trainer Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's Disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

3. The need for information and services may be highest among____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

4. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

5. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from _________________ than those in rural areas.
   a. caregiver support groups
   b. ministers
   c. friends and neighbors
   d. all of the above

6. Among African American caregivers of relatives with Alzheimer's Disease, the decision to make a nursing home placement is most often due to:
   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 7. The rural elderly account for the majority of community mental health patients.

_____ 8. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 9. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 10. African American caregivers experience less caregiver burden or stress than white caregivers.

EVALUATION QUESTIONNAIRE
POST-TEST FOR DAY B TRAINING

Trainer Identification Number____________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

3. The need for information and services may be highest among____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

4. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

5. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from _________________ than those in rural areas.
   a. caregiver support groups
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   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 7. The rural elderly account for the majority of community mental health patients.

_____ 8. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 9. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 10. African American caregivers experience less caregiver burden or stress than white caregivers.

Appendix VI

A Comparison of Full (Two-Day) and Abbreviated (One-Day) Training

ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

A COMPARISON OF FULL (TWO-DAY) AND ABBREVIATED (ONE-DAY) TRAINING

by

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ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

A Comparison of Full (Two-Day) and Abbreviated (One-Day) Training

Training participants who were either identified after the two-day training sessions were completed or who could not attend the sessions scheduled, were invited to attend abbreviated training. Ideally, abbreviated training participants were those who had some background in aging, Alzheimer's Disease, or caregiving since the overview of dementia and caregiving issues were specifically omitted from the abbreviated agenda (see attached agenda). Those who felt the need for extended training in these areas, in addition to the information provided in the training manual were sent supplementary videos subsequent to the training. The panel of representatives from community services agencies was also omitted from the abbreviated training session. It was anticipated that the caregiver resource directories prepared two-day training participants would suffice. Trainers were also urged to carefully study the Caregiver Lesson Plan on Using Formal Supports and Resources and investigate the services available prior to the conduct of caregiver workshops. In addition, materials (brochures, flyers, etc.) provided by members of community resource panels were distributed to abbreviated training participants.

Training content included:

1) a review of the project's purpose and rationale;
2) developing ethnic competence for cross-cultural training;
3) special considerations for trainers of rural caregivers;
4) sensitivity training on building trust and dealing with instances of unintentional abuse or benign neglect;
5) a demonstration of adult learning principles; and
6) specific instruction on how to identify and recruit caregivers, find a training site, conduct the workshops, and collect evaluation information;

The abbreviated training session concluded with a demonstration of how an actual workshop might be conducted.

Knowledge gains were measured with an abbreviated questionnaire sampling the training content (see Abbreviated pre-training and post-training knowledge tests attached). Questions were drawn from the knowledge tests used in the two-day training session. The abbreviated training was evaluated using the same instrument used for the two-day training which included items related to the overall effectiveness and utility of the information provided (see attached evaluation questionnaire). Specifically participants were asked to evaluate the training experience in terms of the extent to which the training was personally and professionally applicable and useful. Participants were also asked to rate the general effectiveness of the training content and presenters, and the quality of the program materials. They were given the opportunity to provide comments through the inclusion of open-ended questions concerning the most and least helpful aspects of the training, and to indicate any relevant issues not included in the training. A summary of the results of data analyses performed on the responses received follows.

Demographic Characteristics

Table 1 shows the frequencies and percentages of those who participated in the two-full days of first level training of trainers. A total of 6 persons provided demographic data. Trainers were equally divided in terms of race, with 3 African American participants and three Caucasians. Two-thirds of the participants were female. When asked to indicate whether they worked or practiced in a rural or urban area, the four of the six respondents chose "rural". The trainers tended to be well educated, with two-thirds possessing advanced degrees (one participant had a high school diploma, but no college degree, and one did not specify level of education). Participants included a caregiver, a minister, a geriatric care manager, and a community service agency worker. One participant did not specify their occupation. With regard to their areas of discipline, one participant was a nurse, one was a theologian, one was a mental health specialist, one had clerical responsibilities, and two did not specify a disciplinary area. Practice settings were unspecified by two respondents, while one worked in a church (the minister), one worked in business/industry (the geriatric care manager), and one worked in a mental health center.

Overall Evaluation

As in the two-day training sessions, participants were asked to use a 1-5 Likert-type scale (with 1 representing "not at all" and 5 representing "to a great extent") to indicate the overall effectiveness of the training and the extent to which their expectations had been met. **Table 2** displays the average rating provided by the six respondents and the associated standard deviations. In general, the training was well-received since the means for all but three questions fell between 4 and 5. The lowest scores were given for the questions regarding: 1) the extent to which the program helped with trainers' problem-solving skills, 2) the extent the program will directly effect practice, and 3) the extent to which the program affected trainers' views about caregivers' quality of life. The mean ratings for these questions fell between 3.5 and 4.0, however, indicating a substantial influence. Since the training was not directly aimed at producing improvements in these areas, the changes documented are remarkable.

Open-Ended Evaluation

Four open-ended questions were included to allow participants to generate their own comments with regard to what they found most and least helpful about the training. The session on ethnic competence was regarded as the most helpful aspect by one participant, another said the session on special considerations for rural trainers was most helpful, one felt the opportunity for group discussion was most helpful, and still another mentioned increased awareness of the need for training. Two of the participants indicated that every aspect of the training was helpful. One participant said that the training manual as the second most important aspect of training and another referred to the session on ethnic competence. When asked about the least helpful aspect of the training, only four participants answered the question and all but one of these indicated that there was no aspect that was not helpful. One respondent expressed a desire for more group discussion. When asked if there were relevant topics not covered in the training, loneliness, sexuality, and infection control were suggested..

Knowledge Gains

Knowledge test items were drawn from information presented in the abbreviated training session and the wording was identical to the two-day training questions. Scoring followed the protocol used for the more extensive training. That is, pre-training and post-training questionnaires were scored by assigning a "1" for correct answers and "0" for incorrect answers. Total scores were computed by summing across the test items for each day, so that the maximum score possible was "16" indicating that all items were answered correctly. The minimum possible was 0, indicating that all items were answered incorrectly. **Table 3** shows the results of the dependent t-test comparing the overall pre-training and post-training scores for the abbreviated training day.

Prior to the training, the average percent score was 66.7% (S.D. = 20.03). That is, participants answered 10.67 of the 16 questions correctly on the average. After training, average percent scores increased to 82.3% (S.D. = 16.02) or 13.17 items correct on the average. This constituted **a statistically significant gain in knowledge** (t = 3.27; p= .0221). Prior to training, two of the respondents answered less than 60% of the questions correctly. After training however, all respondents scored 60% or higher. No respondents obtained a perfect score prior to training, although two answered all items correctly after the training.

In order to further analyze the knowledge gains achieved, an examination of pre-training and post-training performance by item was conducted. **Table 4** shows the results of these analyses. Due in part to the small number of participants, only one item was statistically significant (Item 8 - Precipitants of nursing home placement among African American caregivers). One item approached significance at the .05 level (Item 9 - Appropriate way to teach adults). The failure to reach statistical significance for half of the 16 items (2, 4, 5, 11, 12, 13, 15, 16) could be attributed to a ceiling effect since all participants (or all but one participant) answered correctly prior to training. This finding points to the selection bias employed by project staff who sought participants with a substantial knowledge base for the abbreviated training.

Comparison of Abbreviated (One-Day) and Full (Two-Day) Training Evaluations of Training

Table 5 shows the results of Analyses of Variance comparing the session evaluations provided by participants at the abbreviated (one-day) and full (two-day) training. Both session formats were evaluated equally (p > .05) with regard to the quality of program materials and the overall effectiveness of the training content. There were no statistically significant differences (p > .05) between abbreviated and two-day training session participants in terms of the extent to which the program: 1) broadened trainers knowledge base; 2) helped with their problem solving techniques; 3) directly effected their practices; or 4) affected their view of caregivers' quality of life. In other words, both groups of trainers provided equally high ratings for these evaluation items. However, those who participated in the abbreviated training tended to indicate that the program was of more use to them personally [F (1,48) = 3.67, p = .0613] and that the speakers were more effective [F (1,47) = 3.46, p = .0691] than those who attended the two-day training sessions. The ANOVAs approached significance at the .05 level for these two comparisons.

Differences in Knowledge Gains between Abbreviated (One-Day) and Full (Two-Day) Training Participants

No direct comparisons in overall knowledge gains were feasible, since the knowledge test items were not the same. Total knowledge scores were calculated differently and were therefore not equivalent in the two formats. The 16 items which comprise the abbreviated knowledge test, however, were drawn from the longer knowledge tests employed on the two training days for the more extended training. Participants were compared in terms of their responses to the 16 items common to both groups. **Table 6** summarizes the results of analyses of covariance (ANCOVAs) comparing the two groups of participants in terms of the knowledge gains achieved on the common test items used in both the abbreviated and full training sessions.

The two groups of participants differed significantly with regard to only one of the 16 shared knowledge test items. Adjusting for pre-training differences, the comparison revealed that abbreviated training participants scored higher after training on the item pertaining to the use of extended family caregivers among African American families (Item 3). The F statistic comparing least square means for this ANCOVA was statistically significant [F (2, 53) = 10.83, p = .0018]. An examination of the post-training responses for the two groups revealed that half of abbreviated trainers answered this question correctly on the post-training test, compared to less than 8% of two-day participants. Participants also tended to differ with respect to their responses on the item concerning the determinants of nursing home placement among African American caregivers (Item 8). The F statistic comparing least square means for this ANCOVA approached significance [F (2,53) = 3.23, p = .0780]. An examination of the training responses for the two groups revealed that half of abbreviated trainers answered this question correctly on the post-training test, compared to 32% of two-day trainers. Although none of the other items resulted in statistically significant differences an examination of least square means revealed substantial discrepancy between groups of participants in terms of four other items (1, 7, 10, & 14). For two of these items (1 & 7) abbreviated trainers scored higher than two-day participants and the trend was reversed for two items (10 & 14). It is possible that with a larger sample of abbreviated trainers, these items would have yielded statistically significant differences.

Summary

Abbreviated training participants were racially mixed, predominantly rural; mostly female, and highly educated. In these respects, they are similar to the demographic profile of two-day trainers (see "An Evaluation of First Level Training" report). The training was well received with high marks in all areas of evaluation. A statistically significant overall gain in knowledge was demonstrated. An examination of knowledge gains by item, however, failed to reveal significant differences in response to pre-training and post-training items with respect to all but one item. This was attributed to the small sample size and a ceiling effect resulting from an intentional selection bias. Abbreviated training participants tended to differ from those who attended more extensive training with respect to their evaluations of the program's usefulness and the overall effectiveness of the speakers. With such a small sample participating in the abbreviated training, it is difficult to attribute the differences to format alone since other factors may have contributed. For example, abbreviated trainers may have been especially grateful that project staff would make special arrangements to accommodate their inability to attend the more extensive training. This "halo effect" may in part account for the higher evaluation marks obtained from abbreviated training participants. Differences in overall knowledge gains between the two groups could not be directly ascertained since the knowledge test employed were not equivalent. A comparison in terms of the 16 shared knowledge test items included on the instruments used, however, indicated a statistically significant difference in terms of only one item. Group differences with respect to one other item approached significance. Again it is difficult to draw any firm conclusions due to the limited sample size, but an examination of least square means indicated that abbreviated trainers may have learned more than two-day participants on two additional items. Yet, the adjusted post-training scores of two-day training participants were substantially higher on two of the knowledge test items. There was no clear trend, then, leading to the conclusion that abbreviated training was superior to the more extended training format. Because abbreviated training participants were in one sense, self-selected, and in another sense, biased by the project staff's preference for those with a considerable knowledge base in the areas of Alzheimer's Disease and caregiving. A more rigorous comparison with participants randomly assigned to training formats is the only way to obtain a definitive conclusion regarding the advantages or disadvantages inherent to each of the training experiences provided. The comparison reported here was an attempt to obtain a rough estimate given the constraints mentioned. Unfortunately, results were not clear enough to warrant even an educated guess.

Virginia Center on Aging in Cooperation with the
Virginia Geriatric Education Center presents

Assisting Caregivers of African American and Rural Elders with Dementia: Progressive Training Through Trusted Resources

Agenda Abbreviated Training - January 6, 1994 - John Tyler Community College

9:00 a.m.	Registration and Refreshments
9:15 a.m.	Welcome and Introductions Ruth B. Finley
9:30 a.m.	Pre-Test Evaluation
9:45 a.m.	Review of Purpose and Rationale for Training Constance L. Coogle
10:00 a.m.	Ethnic Competence for Trainers of African American Caregivers Michael A. Pyles
11:00 a.m.	Break
11:15 a.m.	Special Considerations for Trainers of Rural Caregivers Joan B. Wood
12:00 p.m.	Building Trust Constance L. Coogle
12:30 p.m.	Lunch
1:30 p.m.	How Adults Learn Ruth B. Finley
2:00 p.m.	How to Recruit Caregivers/Conduct Workshops - Part I Constance L. Coogle
2:45 p.m.	Break
3:00 p.m.	How to Recruit Caregivers/Conduct Workshops - Part II Ruth B. Finley
3:30 p.m.	Evaluation of Training/Post-Test
3:45 p.m.	Forming Teams
4:00 p.m.	Wrap Up

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VIRGINIA CENTER ON AGING TRAINING EVALUATION - ABBREVIATED

Trainer Identification Number: ______________________________

______

I. PARTICIPANT BACKGROUND

Please fill in your numerical response to the right of each question. For sections A through E, select the corresponding number from the attached code sheet.

A. Race/Ethnicity ____

B. Highest Level of Education ____

C. Discipline ____

D. Occupation ____

E. Practice Setting ____

F. Area of Work or Practice ____
  1. Rural
  2. Urban

G. Gender ____
  1. Female
  2. Male

H. Approximate percentage of your workshop participants who will be aged 60 or above ____

I. Approximate percentage of your workshop participants who will be members of ethnic minority groups ____

J. Approximate percentage of your older workshop participants who will be from rural areas ____

K. Approximate percentage of your total workshop participants who will be aged 60+ and:
  1. Female ____
  2. Male ____

Circle the appropriate number with 1 representing "not at all" and 5 representing "to a great extent."

LOW HIGH

A. To what extent have your expectations been met?

1. Quality of program material (audio-visuals and handouts)
   1 2 3 4 5

2. Usefulness of this program to you
   1 2 3 4 5

B. 1. To what extent did the program broaden your knowledge base?
   1 2 3 4 5

2. To what extent did the program help you with problem-solving techniques?
   1 2 3 4 5

3. To what extent do you foresee that this program will have a direct effect on your practices?
   1 2 3 4 5

4. To what extent did this program affect your view of your participants' quality of life?
   1 2 3 4 5

C. How would you rate the overall effective of this training?

1. Overall effectiveness of the training content
   1 2 3 4 5

2. Overall effectiveness of the trainers/presenters
   1 2 3 4 5

D. 1. What were the most helpful aspects of this training?

____

____

2. What were the least helpful aspects of this training?

____

____

E. 1. Were there relevant topics not covered in this training (please specify)?
   [ ] yes [ ] no

2. Please identify those topics which were not covered from those listed on the attached code sheet (II-E Most Vital Topics) and list the corresponding code numbers below.

____

____

EVALUATION QUESTIONNAIRE
PRE-TEST FOR ABBREVIATED TRAINING

Trainer Identification Number____________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's Disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. In rural areas dementia is probably:
   a. under-diagnosed.
   b. over-diagnosed.
   c. more prevalent than in urban areas.
   d. less prevalent than in urban areas.

3. African American elders are _____________ to be cared for exclusively by primary (blood-related) family members.
   a. less likely
   b. more likely
   c. equally likely

4. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

5. The need for information and services may be highest among_____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

6. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

7. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from ________________ than those in rural areas.
   a. caregiver support groups
   b. ministers
   c. friends and neighbors
   d. all of the above

8. Among African American caregivers of relatives with Alzheimer's Disease, the decision to make a nursing home placement is most often due to:
   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

9. ______________________ is the appropriate way to teach children, while _____________ is the best way to teach adults.
   a. Andragogy, pedagogy
   b. Pedagogy, andragogy
   c. Telegogy, envirogogy
   d. Envirogogy, telegogy

10. Older adult learners may have difficulty learning because of:
   a. medications.
   b. presbyopia.
   c. presbycusis.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 11. There may be a higher prevalence of dementia among African Americans due to an increased risk of stroke due to high blood pressure.

_____ 12. The rural elderly account for the majority of community mental health patients.

_____ 13. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 14. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 15. African American caregivers experience less caregiver burden or stress than white caregivers.

_____ 16. African American caregivers of family members with Alzheimer's Disease rely more on prayer and religion than white caregivers as a means of coping.

EVALUATION QUESTIONNAIRE
POST-TEST FOR ABBREVIATED TRAINING

Trainer Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Which of the following is not a barrier that affects service utilization among minority elders and their families?
   a. actual or perceived racial discrimination
   b. a lower incidence of Alzheimer's Disease and related dementias among minority groups.
   c. lack of familiarity with services and providers.
   d. lack of minority involvement in service planning and needs assessment.

2. In rural areas dementia is probably:
   a. under-diagnosed.
   b. over-diagnosed.
   c. more prevalent than in urban areas.
   d. less prevalent than in urban areas.

3. African American elders are ____________ to be cared for exclusively by primary (blood-related) family members.
   a. less likely
   b. more likely
   c. equally likely

4. Which of the following is not a barrier that affects service utilization among rural elders and their families?
   a. limited communication about service availability.
   b. geographic isolation and transportation difficulties.
   c. negative attitudes about receiving outside assistance.
   d. extensive social and economic diversity.

5. The need for information and services may be highest among____________ caregivers of elders with Alzheimer's Disease.
   a. rural, White
   b. rural, African American
   c. urban, White
   d. urban, African American

6. The proportion of the population in nonmetropolitan areas that is elderly is ____________ the proportion of the population in metropolitan areas that is elderly.
   a. larger than
   b. smaller than
   c. the same as

7. Urban caregivers of elders with Alzheimer's Disease are more likely to receive support from _________________ than those in rural areas.
   a. caregiver support groups
   b. ministers
   c. friends and neighbors
   d. all of the above

8. Among African American caregivers of relatives with Alzheimer's Disease, the decision to make a nursing home placement is most often due to:
   a. lack of support from other family members and friends.
   b. increased conflict with the patient.
   c. loss of faith.
   d. all of the above.

9. ______________________ is the appropriate way to teach children, while ____________ is the best way to teach adults.
   a. Andragogy, pedagogy
   b. Pedagogy, andragogy
   c. Telegogy, envirogogy
   d. Envirogogy, telegogy

10. Older adult learners may have difficulty learning because of:
   a. medications.
   b. presbyopia.
   c. presbycusis.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 11. There may be a higher prevalence of dementia among African Americans due to an increased risk of stroke due to high blood pressure.

_____ 12. The rural elderly account for the majority of community mental health patients.

_____ 13. The values of rural elders are "post figurative," that is passed down from older to younger persons.

_____ 14. Overall, African Americans who reside in nursing homes are somewhat less functionally impaired than white residents.

_____ 15. African American caregivers experience less caregiver burden or stress than white caregivers.

_____ 16. African American caregivers of family members with Alzheimer's Disease rely more on prayer and religion than white caregivers as a means of coping.

TABLE 1. Demographic Characteristics of Abbreviated Training Participants (N=6)

Demographic Category	n	%
Ethnicity of Participants		
African American	3	50.0%
Caucasian	3	50.0%
Gender of Participants		
Male	2	33.3%
Female	4	66.7%
Area of Work or Practice		
Rural	4	66.7%
Urban	2	33.3%
Highest Level of Education		
Less than Bachelor Degree	1	16.7%
More than Bachelor Degree	4	66.6%
Unspecified Other	1	16.7%
Discipline of Participant		
Nursing	1	16.7%
Theology	1	16.7%
Mental Health	1	16.7%
Clerical	1	16.7%
Unspecified Other	2	33.2%
Occupation		
Community Service Agency	1	16.7%
Private Practice	1	16.7%
Minister	1	16.7%
Caregiver	1	16.7%
Unspecified Other	2	33.2%
Setting		
Business/Industry	1	20.0%
Mental Health Center	1	20.0%
Church	1	20.0%
Unspecified Other	2	40.0%

TABLE 2. Results of Evaluation Questionnaire Completed By Abbreviated Training Participants (N=6)*

Evaluation Question	Mean	Std. Dev.
Overall Effectiveness of Trainers/Presenters	4.83	0.41
Usefulness of Program	4.83	0.41
Quality of Program Material	4.67	0.52
Extent Program Broadened Knowledge Base	4.50	0.84
Overall Effectiveness of Training Content	4.50	0.55
Extent Program Affected View of Caregivers' QOL	3.83	1.47
Extent Program Will Directly Effect Practice	3.83	0.98
Extent Program Improved Problem-Solving Ability	3.67	0.82

* Items rated on 5-point Likert-type scale

TABLE 3. Results of Pre-Training and Post-TrainingKnowledge Test Total Scores for Abbreviated Training Participants (N=6)

Testing Time	Average % Score	Standard Deviation
Pre-Training	66.67%	20.03
Post-Training	82.29%	16.02

$t = 3.27$

$p = .0221$

TABLE 4. Results of Abbreviated Pre-Training and Post-Training Knowledge Test Items (N=6)[*]

Knowledge Test Item	Pre %	Post %	t	p
1) Barriers to minority service utilization	66.7%	100.0%	1.58	.1747
2) Under-diagnosis of dementia in rural areas	83.3%	100.0%	1.00	.3632
3) Extended-family caregivers in African American communities	16.7%	50.0%	1.00	.3632
4) Barriers to rural service utilization	83.3%	83.3%	0.00	1.000
5) Greatest need for information and services among rural, African Americans	83.3%	100.0%	1.00	.3632
6) Relative proportion of population that is elderly in metropolitan/non-metropolitan areas	66.7%	66.7%	0.00	------
7) Participation in AD support groups among urban versus rural caregivers	33.3%	50.0%	1.00	.3632
8) Precipitants of nursing home placement among African American caregivers	33.3%	100.0%	3.16	.0250
9) Appropriate way to teach adults	33.3%	83.3%	2.24	.0756
10) Learning difficulties among older adults	50.0%	66.7%	1.00	.3632
11) Higher prevalence of dementia among African Americans	83.3%	100.0%	1.00	.3632
12) Under-utilization of community mental health services by rural elderly	83.3%	83.3%	0.00	------
13) Post-figurative values in rural communities	100.0%	100.0%	0.00	------
14) Greater functional impairment among African American nursing home residents	66.7%	50.0%	-1.00	.3632
15) Equal levels of burden reported by African American and Caucasian caregivers	100.0%	83.3%	-1.00	.3632
16) Greater reliance on prayer and religion among African American caregivers	83.3%	100.0%	1.00	.3632

[*] Percentages refer to proportion of participants answering item correctly

TABLE 5. Comparison of Abbreviated and Two-Day Participants' Evaluation of Training

Evaluation Item	Mean	Std. Dev.	F	df	p
Quality of Program Material					
Abbreviated (n=6)	4.67	0.52			
Two-Day (n=44)	4.36	0.56	1.55	1,48	.2192
Usefulness of Program					
Abbreviated (n=6)	4.83	0.41			
Two-Day (n=44)	4.43	0.49	3.67	1,48	.0613
Overall Effectiveness of Trainers/Presenters					
Abbreviated (n=6)	4.83	0.41			
Two-Day (n=44)	4.42	0.52	3.46	1,47	.0691
Overall Effectiveness of Training Content					
Abbreviated (n=6)	4.50	0.57			
Two-Day (n=44)	4.33	0.55	0.48	1,48	.4936
Program Broadened Knowledge Base					
Abbreviated (n=6)	4.50	0.84			
Two-Day (n=44)	4.25	0.68	0.68	1,48	.4132
Program Improved Problem-Solving Ability					
Abbreviated (n=6)	3.67	0.82			
Two-Day (n=44)	4.03	0.63	1.68	1,47	.2019
Program Will Directly Effect Practice					
Abbreviated (n=6)	3.83	0.98			
Two-Day (n=44)	4.30	0.61	2.58	1,48	.1149
Program Affected View of Caregivers' QOL					
Abbreviated (n=6)	3.83	1.47			
Two-Day (n=44)	4.01	0.63	0.28	1,46	.5964

TABLE 6. Comparison of Abbreviated and Two-Day Participants' Least Square Means for Knowledge Test Items via Analyses of Covariance[*]

Knowledge Test Item	Abbr.	Std. Err.	Two-Day	Std. Err.	F	df	p
1) Barriers to minority service utilization	96.7%	0.16	70.4%	0.06	0.51	2,53	.4802
2) Under-diagnosis of dementia in rural areas	100.0%	0.09	93.9%	0.03	0.51	2,53	.4802
3) Extended-family African American caregivers	51.9%	0.13	7.8%	0.04	10.83	2,53	.0018
4) Barriers to rural service utilization	80.4%	0.17	72.4%	0.06	0.21	2,53	.6522
5) Information/services need among rural, blacks	91.1%	___	91.1%	---	----	2,53	----
6) Elderly proportion of metro/non-metro population	65.7%	0.20	64.1%	0.07	0.94	2,53	.9396
7) Urban vs. rural support group participation	50.3%	0.18	32.0%	0.06	0.96	2,53	.3321
8) NH placement among African American caregivers	92.7%	0.19	56.9%	0.06	3.23	2,53	.0780
9) Way to teach adults	83.3%	0.17	76.8%	0.06	0.12	2,59	.7264
10) Learning difficulties among older adults	68.9%	0.14	87.3%	0.05	1.52	2,59	.2224
11) Prevalence of dementia among African Americans	100.0%	0.08	95.9%	0.03	0.39	2,53	.5336
12) Under-utilization of rural community mental health	75.1%	0.16	69.0%	0.06	0.13	2,53	.7231
13) Post-figurative values in rural communities	92.9%	0.07	92.9%	0.02	0.00	2,53	1.0000
14) NH functional impairment	51.1%	0.19	61.9%	0.07	0.28	2,53	.5977
15) African American vs. Caucasian caregiver burden	82.5%	0.13	90.1%	0.04	0.30	2,53	.5844
16) Prayer/religion among African American caregivers	100.0%	0.05	97.9%	0.02	0.14	2,53	.7120

[*] Percentages refer to adjusted post-training proportion of participants answering item correctly

Appendix VII

Calculations for Time Commitment by Trainers

Participation in Workshops

TRAINERS	WORKSHOP	NO.	TIME	PERSON HOURS
Ellison Russell	1	19	4	76
	2	15	4	60
Roberts Henderson Hendrick	1	4	2	8
	2	9	1	9
	3	7	2	14
	4	3	2	6
Wood Skinner	1	8	2.5	20
	2	8	2.5	20
	3	5	3	15
Cofield Rabon	1	2	2.5	5
	2	6	2.5	15
	3	5	3	15
Pugh Carson	1	13	6	78
	2	13	6	78
Haddix Duncan	1	6	2.5	15
Hasty	1	5	2	10
Morris Bates	1	5	2.5	12.5
	2	2	3	6
	3	3	3	9
	4	3	3	9
Dyson Cooper Flippen Grooms	1	1	2	2
	2	9	4.5	40.5
Parrish Harris	O	15	1	15
	1	12	2.5	30
	2	14	2.5	35
	3	10	2.5	20.5
	4	10	2.5	20.5

Bugg				
Maxfield	1	18	3	54
	2	18	3	54
	3	18	3	54
Chapman	1	13	1.75	22.75
Ragland	2	11	1.5	16.5
Thompson	3	11	1	11
Coleman	4	11	.25	2.75
Gholson	5	11	.5	5.5
Bagby				
Johnson				
Robinson				
Miles				
Carter				
Motley	1	12	3.5	42
	2	6	3.5	21
	3	10	3	30
Jones				
Jackson				
Dickman	1	9	2	18
	2	7	2	14
	3	8	2	16
	4	4	2	8
	5	7	2	14
Jones-Clarke				
Ward	1	5	2.5	12.5
	2	6	3	18
	3	4	3	12
Knutsen				
Hinchey	1	6	3.75	22.5
	2	4	3.75	15
	3	2	2.5	5
Carter-Allmond	1	22	1.5	33
	2	16	1.5	24
	3	15	1.5	22.5
Baker				
Atkins	1	6	3.25	19.5
	2	8	3.25	26
Boger				
Crawley	1	11	2	22
	2	9	2.25	20.25
	3	9	2.25	20.25
	4	7	2	14
	5	5	2	10
	6	7	2.5	17.5
			--------	--------
			392.5	1,341.5

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Appendix VIII

An Evaluation of Second Level Training

Appendix VIII-A: Original Pre-Workshop, Post-Training Workshop Questionnaires
Appendix VIII-B: Revised Pre-Workshop, Post-Workshop Questionnaires
Appendix VIII-C: Workshop Evaluation Questionnaire

ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

AN EVALUATION OF SECOND LEVEL TRAINING

by

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November 30, 1994

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ASSISTING CAREGIVERS OF AFRICAN AMERICAN AND RURAL ELDERS WITH DEMENTIA: PROGRESSIVE TRAINING THROUGH TRUSTED RESOURCES

An Evaluation of Second Level Training

Knowledge Gains

Knowledge test items were drawn from the mini-lecture content for each of the 9 essential or required Modules or Caregiver Lesson Plans (see Appendix A for knowledge tests used). Both multiple choice and true-false items were included. Since most trainers covered all of the essential modules, 9 separate pre-workshop and 9 post-workshop tests were distributed. The post-workshop tests were identical to the pre-workshop tests, except for the designation of "Pre-Test" or "Post Test," and the color of the paper used. Using two-different colors made it easier to tell at a glance that all participants were working on the pre-workshop tests prior to the beginning of the mini-lecture and on the post-workshop tests after the conclusion of the mini-lecture.

To demonstrate knowledge gains, pre-workshop and post-workshop questionnaires were scored by assigning a "1" for correct answers and "0" for incorrect answers. If trainers failed to obtain tests for a particular module, or if a caregiver did not answer the items, items were scored as missing. Total knowledge scores were computed by summing across the items contained in each of the nine modules, so that the maximum score possible was "59." The minimum possible was 1. If participants did not answer any items, the total knowledge score was missing. Percentage scores were calculated by dividing the total knowledge score by the number of items answered. **Table 1** shows the results of dependent $\underline{t}$-tests comparing the overall pre-workshop and post-workshop scores.

Prior to the mini-lecture, the average percent score was 61.47% (S.D. = 12.30). That is, participants answered 21.55 of the 59 questions correctly on the average. After training, average percent scores increased to 74.03% (S.D. = 14.28) or 26.30 items correct on the average. This constituted **a statistically significant gain in knowledge** ($\underline{t}$ = 13.54; $\underline{p}$= .0001).

Table 2 shows an examination of scale scores computed for each of the nine modules individually. Statistically significant knowledge gains were demonstrated for each content area. The greatest gains were found for Module 3: Coping with Stress, while the least gains were noted for Module 2: Caregiver Burden. Although the pre-workshop scores for these two modules were substantially lower than for the other nine essential content areas, participants appeared to learn a great deal about how to cope with stress, while their understanding of caregiver burden remained incomplete.

In order to further analyze the knowledge gains achieved, an examination of pre-workshop and post-workshop performance by item was conducted. **Tables 3-11** show the results of these analyses for each of the nine modules. In order to compensate for inflated alpha levels with the conduct of numerous t-tests, the level of significance was set at .01 for purposes of these analyses. Applying this criterion, statistically significant improvements in knowledge were found with regard to the following items:

Module 1: Overview of Dementia and Alzheimer's Disease - the definitions of dementia and AD, autopsy as the most conclusive diagnostic method for determining AD, and the brain cell deterioration associated with AD. (4 of 8 items)

Module 2: Caregiver Burden - the various roles that effective caregivers play and the three major components of caregiver burnout. (2 of 7 items)

Module 3: Coping with Stress - the definitions of Eustress, the "fight or flight syndrome," and progressive relaxation. (3 of 5 items)

Module 5: Legal and Financial Issues - the extended validity of the durable health care power of attorney, witnesses needed for the health care power of attorney, and the need to notarize the durable general power of attorney. (3 of 5 items)

Module 7: Managing the Daily Routine - how to best facilitate the task of dressing the person with dementia, the calorie requirement of older vs. younger persons, the definition of Apraxia, the inadvisability of using bath oil, and the importance of maintaining the daily routine for persons resistive to ADL assistance. (5 of 7 items)

Module 12: Formal Supports and Resources - advise when calling for formal assistance, Medicare Part B coverage, and the purpose of the Virginia Long Term Care Council. (3 of 7 items)

Module 14: Managing Resistive Behavior - the stage of AD when true incontinence occurs. (1 of 6 items)

Module 16: Communicating with the Patient - language problems associated with dementia, the continued understanding of language in uncommunicative persons with AD, the inadvisability of using "baby talk," and the advantages of reducing background noise when communicating with a person with dementia. (4 of 6 items)

Module 21: 24 Hour Care - who should make the placement decision and the importance of caregiver participation in the care plan. (2 of 7 items)

In addition, items statistically significant at the .025 alpha level, suggesting substantial gains in knowledge included:

Module 1: Overview of Dementia and Alzheimer's Disease - forgetfulness as the primary symptom of AD in the early stage and AD as a diagnosis of exclusion. (2 of 8 items)

Module 2: Caregiver Burden - the definition of depersonalization. (1 of 7 items)

Module 7: Managing the Daily Routine - the inability to gauge temperature among persons with dementia. (1 of 7 items)

Module 14: Managing Resistive Behavior - dealing with ADL difficulties. (1 of 6 items)

Module 21: 24 Hour Care - the nurses aide as the member of the health time who spends the most time with the patient and the importance of geographical proximity when choosing a nursing home. (2 of 7 items)

To sum, 27 of the 59 items (or 45.76%) resulted in statistically significant knowledge gains at the .01 alpha level, and 7 of the 59 items (11.86%) resulted in statistically significant knowledge gains at the .025 alpha level. Overall, then, the majority of items (57.63%) were indicative of increases in knowledge. Comparisons across modules indicate that Module 7: Managing the daily routine contained the greatest proportion of items (85.7%) resulting in statistically significant knowledge gains, while Module 14: Managing Resistive Behavior contained the smallest proportion of items (33.3%) resulting in statistically significant knowledge gains. The remaining modules are ranked with respect to the proportion of items resulting in statistically significant knowledge gains as follows:

Module 1: Overview of Dementia and AD (75%)
Module 16: Communicating with the Patient (66.6%)
Module 3: Coping with Stress (60%)
Module 21: 24 Hour Care (57.1%)
Module 5: Legal and Financial Issues (50%)
Module 12: Formal Supports and Resources (42.9%)
Module 2: Caregiver Burden (42.9%)

It is difficult to ascertain whether these results are a consequence of differences in: 1) the emphasis trainers tended to place on various content areas as a consequence of caregivers' need for information, or 2) the difficulty of the content material. What can be discovered, however, is whether differences in the discriminative ability of the items chosen for the different modules contributed.

Item Analysis

The value of testing instruments rest in their questions or items. Some test items may be more effective than others in reflecting true levels of knowledge. That is, some items are more likely to be answered correctly by those who performed best on the overall test. Conversely, some items may be answered incorrectly by the best-scoring respondents. Any attempt to evaluate the functional utility of testing instruments should be based on this kind of determination. Also, when developing or streamlining tests for future use it is important to know which items may be excluded. In general, those items which show the greatest degree of discriminative ability between high, moderate, and low scoring respondents should be retained, while those which result in approximately equal proportions of correctly-scoring respondents in each scoring group should be dropped.

Respondents were categorized into three groups based on their total post-workshop knowledge scores. Criterion cut-off points were set so that each subgroup would contain roughly one third of the participants. Those scoring 80.77% or more were assigned to the high group, those scoring 69.23% or less were assigned to the low group, and respondents with scores falling in between were assigned to the moderate group. After setting these criterion cutoff points, 32.8% of respondents constituted the low-scoring group, 33.9% of respondents were designated as scoring in the moderate range, and the remaining 33.3% comprised the high-scoring group. The post-workshop total knowledge score average for the low-scoring group was 22.21 (or 57.7% correct) and the standard deviation was 11.91. For the moderate-scoring group, the average was 26.41 (or 75.3% correct) and the standard deviation was 13.94. The high-scoring group had a mean of 30.22 (or 88.7% correct) and the standard deviation was 17.64. Analysis of variance revealed that the three scoring groups differed significantly in terms of their post-workshop performance on the knowledge test; $\underline{F}$ (2, 171) = 313.34, $\underline{p}$ = .0001.

Tables 12-20 show the results of the item analyses performed for each of the 9 essential or required modules. An item was deemed as ideally discriminating when the majority of low scorers answered incorrectly, the majority of high scorers answered correctly, and approximately half of the moderate scorers answered correctly. Employing these criteria, 8 of the 59 items showed ideal discriminative ability. Since a substantial proportion of respondents in each scoring group answered correctly, 16 of the items were judged "too easy." Since a substantial proportion of respondents in each scoring group answered incorrectly, 4 items were judged "too difficult." Apart from these considerations, 17 of the items showed some degree of linear discriminative ability since the percentage of correct respondents increased linearly across the low, moderate, and high scoring groups. That is, the low scoring group had the lowest percentage of respondents with correct answers, the moderate scoring group had the next highest percentage of correct responding members, and the high scoring group had the greatest percentage of correct scoring respondents. Ideal discrimination was not achieved however. In some cases more than one-half of the low scoring respondents answered correctly, in other cases the proportion of moderately scoring respondents who answered correctly was substantially greater than one-half. Some items showed partial linearity, failing to discriminate between low and moderately scoring groups or alternatively, between moderately and high scoring groups.

Revised knowledge tests can be constructed after considering the results of the item analyses (see Appendix B). Items were discarded if they were deemed "too easy" or "too difficult." Items which showed complete or partial linearity were retained for use, along with items that ideally discriminated, in the revised testing instruments. **Tables 21-29** summarizes the results of the item analyses and the pre-workshop, post-workshop comparison of caregiver performance. The failure to find statistically significant differences in retained items may be attributed to the collective failure of trainers to effectively "teach" the educational content sampled by those particular pieces of information. Since dropping those items would contradict the results of item analysis, they should be retained for future use, and reanalyzed employing different trainers and different caregiver participants.

Out of the 59 items employed in caregiver knowledge tests, the majority (34 or 57.63%) were indicative of statistically significant increases in knowledge at either the .01 or .025 alpha level. A total of 20 items were dropped when revising the knowledge tests because they were either too easy or too difficult. The remaining 39 items were included in the revised tests because they showed ideal discriminative ability, or because they showed linear or partially linear trends.

Workshop Evaluation Questionnaire

At the end of each workshop, trainers were asked to distribute a Workshop Evaluation Questionnaire (see Appendix C). Caregivers were asked to use a 1-5 Likert-type scale (with 1 representing "not at all" and 5 representing "extremely") to indicate the overall effectiveness of the trainers and the extent to which they felt the workshop experience was worthwhile. Specifically the Workshop Evaluation Questionnaire asked attendees to give some basic demographic data (i.e., gender, race, place of residence) and indicate the extent to which: 1) the material covered in the workshop was relevant to their particular problems and concerns, 2) attending this workshop made them more aware of help available in the community, 3) they were more likely to use community resources as a consequence of attending the workshop, 4) they gained a better understanding of their care recipients, 5) they gained better understanding of their own feelings about their care recipients, 6) they gained a better understanding of how they can help their care recipients live happier lives, 7) they learned to be better caregivers, 8) the material covered in the workshop was useful in general, and 9) the trainer effectively communicated the workshop content. **Table 30** displays the demographic characteristics of the 165 caregivers who responded to the Workshop Evaluation Questionnaire. Almost threfe-quarters of respondents were African Americans and the majority (about 85%) were women. Almost three-quarters lived in rural areas. **Table 31** shows the average rating provided by all respondents across all the workshop sessions, the associated standard deviations, and the numbers of respondents who answered each question. The number of respondents fell off for the last four items on the instrument because some caregivers (about 20) failed to turn the questionnaire over and answer the questions on the back side. In general, the training was well-received since the means for all questions were greater than the middle range score of 3. The lowest scores were given for the questions regarding the extent to which they were more aware of and more likely to use community resources. Since only one Caregiver Lesson Plan was specifically designed to address these issues, the result is not surprising. The next lowest ratings were provided for the items pertaining to increased self-knowledge or empathy for the care recipients and improving the care recipients' quality of life. Since none of the Caregiver Lesson Plans were specifically intended to produce these outcomes, the relatively high ratings are particularly noteworthy. The highest ratings were given for the items concerning the effectiveness of trainers and the utility of the information presented. Caregivers also indicated that: 1) the workshop content was pertinent to their personal concerns, 2) they learned to be better caregivers, and 3) they acquired insight about their care recipients.

On the average, caregivers completed Workshop Evaluation Questionnaires for 1.8 workshop sessions (SD = 1.22). About two thirds (61.8%) of caregivers completed only one questionnaire. (Note: Some trainers held all day workshop sessions and only collected data at the end of the day-long session). More than one-quarter (26%) of caregivers completed two or three questionnnaires, and some (4.2%) completed as many as 5 or 6.

When asked about the usefulness of the handout material (reproduced by trainers from documents included in the training manual), 122 respondents indicated that they had received at least some of that material at some point during the workshop series. The material was judged to be quite useful (X=4.07; SD = 1.12). With regard to the videos that trainers were encouraged to obtain and use in conjunction with their mini-lectures, 51 respondents indicated that they had viewed some video material at some point during the workshop series. As with the handouts, the video supplements were regarded as quite useful (X= 3.97; SD= 1.19) by those who were fortunate enough to have the opportunity.

Interestingly, there were some Caregiver Lesson Plans that were not covered by any of the trainers (Module 4: Sharing Responsibilities, Module 6: The Grieving Process, Module 11: Compliance/Non-Compliance with Drugs Used by Dementia Patients, Module 15: Managing Wandering, Module 17: The Caregiver's Spiritual Resources, and Module 18: Compassionate Caregiving). Trainers were allowed to use discretion about the workshop content in order to address the most immediate needs for information. It is likely that time constraints contributed to the amount of material covered as well. Some Modules were quite lengthy and would have taken considerable time to thoroughly complete. If trainers touched on some of the content in a particular module without formally presenting the mini-lecture, the data would not be reflective.

Two open-ended questions were included to allow participants to generate their own comments with regard to what they found most and least helpful about the workshops. With regard to the most helpful aspect, many caregivers indicated that everything about the workshop was helpful. The most popular other responses included:

1) Learning the importance of caregivers taking care of themselves in order to take better care of the care recipient;
2) Learning from others with similar experiences;
3) Handouts distributed by trainers;
4) Gaining an in-depth understanding of the disease; and
5) Group support.

Other responses mentioned by more than a few participants included the trainers, and learning about legal issues, coping with stress, and Cognex. With regard to the least helpful aspect of the workshops, many caregivers indicated that all aspects were helpful. The most popular other responses included the paperwork, i.e., completing evaluation questionnaires, and the lack of sufficient time alloted to cover a particular topic.

The results of the Workshop Evaluation Questionnaires indicate that the workshop content was relevant to the personal problems and concerns of caregivers. Caregivers learned a great deal about AD, caregiving, and other information included in the mini-lectures for each of the Caregiver Lesson Plans. They became more aware of community resources available to help them with their caregiving responsibilities and, as a consequence of attending the workshops, they are more likely to access the available help.

TABLE 1. Results of Caregiver Knowledge Test Total Percentage Scores (N=174)

Testing Time	Average % Score	Standard Deviation
Pre-Workshop	61.47%	12.30
Post-Workshop	74.03%	14.28

t = 13.54

p = .0001

TABLE 2. Results of Caregiver Knowledge Test Scales[*]

Knowledge Test Scale	Pre %	Post %	t	p
1: Overview of Dementia/AD (n=132)	60.8%	74.8%	7.62	.0001
2: Caregiver Burden (n=125)	49.7%	58.6%	4.82	.0001
3: Coping with Stress (n=120)	45.3%	65.4%	8.65	.0001
5: Legal and Financial Issues (n=116)	62.5%	76.4%	6.68	.0001
7: Managing the Daily Routine (n=121)	57.6%	75.1%	7.96	.0001
12: Formal Supports/Resources (n=115)	66.3%	76.0%	5.21	.0001
14: Managing Resistive Behav. (n=87)	68.7%	78.4%	3.90	.0002
16: Communicating with Patient (n=85)	60.7%	77.3%	7.52	.0001
21: 24 Hour Care (n=88)	84.2%	97.3%	5.17	.0001

[*] Percentages refer to proportion of participants answering item correctly

TABLE 3. Results of Caregiver Knowledge Tests[*] Module 1: Overview of Dementia and Alzheimer's Disease

Knowledge Test Item	Pre %	Post %	t	p	n
1) Definition of Dementia	52.1%	67.8%	2.99	.0034	54
2) Definition of Alzheimer's Disease	32.0%	46.4%	2.79	.0062	50
3) Most conclusive diagnostic method	43.2%	87.3%	9.29	.0001	57
4) Primary symptom of AD in early stages	82.3%	92.0%	2.45	.0157	62
5) AD as diagnosis of exclusion	54.0%	66.1%	2.33	.0216	51
6) Brain cell deterioration in AD	84.8%	92.8%	2.74	.0070	50
7) Duration of Alzheimer's Disease	68.0%	66.4%	-0.34	.7331	50
8) Gradual onset of Alzheimer's Disease	79.2%	84.8%	1.30	.1948	50

[*] Percentages refer to proportion of participants answering item correctly

TABLE 4. Results of Caregiver Knowledge Tests[*] Module 2: Caregiver Burden

Knowledge Test Item	Pre %	Post %	t	p	n
1) Roles of the effective caregiver	46.0%	79.6%	6.04	.0001	62
2) Major components of caregiver burnout	4.2%	14.2%	2.91	.0042	55
3) Definition of depersonalization	29.9%	42.7%	2.28	.0247	58
4) Definition of caregiver burnout	47.4%	56.0%	1.52	.1323	59
5) Basic goal of caregiving	99.2%	99.2%	0.00	1.000	52
6) Most frequent type of maltreatment	31.7%	29.3%	-0.50	.6141	52
7) Prevalence of caregiver depression	89.3%	90.9%	0.44	.6566	54

[*] Percentages refer to proportion of participants answering item correctly

TABLE 5. Results of Caregiver Knowledge Tests*
Module 3: Coping with Stress

Knowledge Test Item	Pre %	Post %	t	p	n
1) Kinds of respite	61.2%	62.9%	0.50	.6192	59
2) Definition of Eustress	28.6%	70.5%	7.56	.0001	105
3) Definition of "fight or flight" syndrome	29.2%	70.8%	8.34	.0001	62
4) Symptoms of stress	68.1%	69.9%	0.46	.6850	62
5) Definition of progressive relaxation	36.8%	53.8%	2.92	.0042	58

* Percentages refer to proportion of participants answering item correctly

TABLE 6. Results of Caregiver Knowledge Tests*
Module 5: Legal and Financial Issues

Knowledge Test Item	Pre %	Post %	t	p	n
1) Examples of advance directives	83.2%	85.0%	0.53	.5952	62
2) Durable Health Care Power of Attorney	42.3%	64.4%	3.82	.0002	71
3) Eligibility for Medicaid	46.8%	52.3%	1.09	.2753	66
4) Legal and financial consequences of AD	80.4%	81.3%	0.22	.8284	63
5) Using Health Care Power of Attorney	64.0%	92.1%	5.54	.0001	114
6) Notarizing General Power of Attorney	54.8%	80.0%	4.97	.0001	60

* Percentages refer to proportion of participants answering item correctly

TABLE 7. Results of Caregiver Knowledge Tests*
Module 7: Managing the Daily Routine

Knowledge Test Item	Pre %	Post %	*t*	*p*	*n*
1) Facilitating the task of dressing	53.0%	75.7%	4.72	.0001	60
2) Calorie requirement of older persons	63.6%	78.0%	3.06	.0027	118
3) Definition of Apraxia	30.0%	62.2%	4.97	.0001	85
4) Inadviseability of using bath oil	31.7%	61.7%	6.22	.0001	55
5) Inadviseability of changing daily routine	50.4%	70.9%	4.03	.0001	58
6) Inability to gauge temperature	84.2%	93.3%	2.45	.0157	120
7) Complex grooming activities	81.5%	79.8%	0.42	.6717	56

* Percentages refer to proportion of participants answering item correctly

TABLE 8. Results of Caregiver Knowledge Tests*
Module 12: Formal Supports and Resources

Knowledge Test Item	Pre %	Post %	*t*	*p*	*n*
1) Calling for formal assistance	65.1%	80.2%	3.60	.0005	106
2) Medicare Part B coverage	16.1%	46.4%	6.43	.0001	63
3) Rural AAA's budgets and staff	68.2%	72.0%	0.75	.4523	68
4) Dictates of Older Americans Act	93.8%	96.5%	1.00	.3195	62
5) Virginia Long Term Care Council	70.3%	89.2%	4.18	.0001	64
6) Local Alzheimer's Association Chapter	84.1%	83.2%	-0.24	.8096	62
7) Medicaid vs. Medicare coverage	69.9%	69.9%	0.00	1.000	62

* Percentages refer to proportion of participants answering item correctly

TABLE 9. Results of Caregiver Knowledge Tests[*]
Module 14: Managing Resistive Behavior

Knowledge Test Item	Pre %	Post %	t	p	n
1) Reasons for resistance to bathing	79.6%	75.3%	0.89	.3742	90
2) Stages of AD when incontinence occurs	45.3%	75.6%	5.06	.0001	86
3) Dealing with ADL difficulties	62.1%	75.9%	2.42	.0177	87
4) Restricted water intake for incontinence	66.7%	66.7%	0.00	1.000	91
5) Dealing with mealtime difficulties	74.7%	85.5%	2.11	.0382	83
6) Dressing/grooming and self esteem	96.4%	96.4%	0.00	1.000	91

[*] Percentages refer to proportion of participants answering item correctly

TABLE 10. Results of Caregiver Knowledge Tests[*]
Module 16: Communicating with the Patient

Knowledge Test Item	Pre %	Post %	t	p	n
1) Definition of aphasia	62.7%	72.3%	1.92	.0589	92
2) Dementia-related language problems	29.6%	46.9%	2.65	.0097	94
3) Understanding vs. communicating	23.2%	61.0%	5.69	.0001	82
4) Inadviseability of "baby talk"	74.7%	92.8%	4.25	.0001	92
5) Reducing background noise	83.1%	94.0%	2.82	.0059	83
6) Importance of talking to patient	89.2%	95.2%	1.69	.0958	92

[*] Percentages refer to proportion of participants answering item correctly

TABLE 11. Results of Caregiver Knowledge Tests[*]
Module 21: 24 Hour Care

Knowledge Test Item	Pre %	Post %	t	p	n
1) Cost of institutional care	44.0%	53.6%	1.58	.1172	84
2) Health team members home	77.0%	88.5%	2.42	.0175	87
3) Making the placement decision	73.6%	94.3%	4.19	.0001	88
4) Importance of proximity	79.8%	90.5%	2.58	.0117	88
5) Structured environment	92.0%	88.5%	-1.00	.3201	87
6) Caregiver participation in plan	65.5%	83.3%	3.69	.0004	84
7) The adjustment to placement	72.9%	82.4%	1.91	.0589	85

[*] Percentages refer to proportion of participants answering item correctly

TABLE 12. Item Analysis for Caregiver Knowledge Test[*] Module 1: Overview of Dementia and Alzheimer's Disease

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Definition of Dementia	46.2%	66.7%	90.0%
2) Definition of Alzheimer's Disease	36.6%	38.1%	64.3%
3) Most conclusive diagnostic method	70.3%	92.3%	97.6%
4) Primary symptoms of AD in early stages	83.3%	92.5%	100.0%
5) AD as diagnosis of exclusion	42.9%	70.0%	85.7%
6) Brain cell deterioration in AD	88.1%	95.1%	95.2%
7) Duration of Alzheimer's Disease	61.9%	71.4%	65.9%
8) Gradual onset of Alzheimer's Disease	73.2%	88.1%	92.9%

[*] Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 13. Item Analysis for Caregiver Knowledge Test[*] Module 2: Caregiver Burden

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Roles of the effective caregiver	61.4%	87.8%	96.4%
2) Major components of caregiver burnout	15.2%	11.1%	17.2%
3) Definition of depersonalization	21.7%	38.1%	82.8%
4) Definition of caregiver burnout	45.5%	46.5%	86.2%
5) Basic goal of caregiving	97.9%	100.0%	100.0%
6) Most frequent type of maltreatment	27.7%	34.8%	23.3%
7) Prevalence of caregiver depression	85.1%	97.7%	90.0%

[*] Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 14. Item Analysis for Caregiver Knowledge Test[*] Module 3: Coping with Stress

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Kinds of respite	36.6%	69.0%	87.9%
2) Definition of Eustress	55.3%	67.5%	96.3%
3) Defintion of "fight or flight" syndrome	58.5%	66.7%	90.9%
4) Symptoms of stress	56.1%	71.8%	84.8%
5) Definition of progressive relaxation	47.6%	50.0%	66.7%

[*] Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 15. Item Analysis for Caregiver Knowledge Test[*] Module 5: Legal and Financial Issues

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Examples of advance directives	69.2%	84.8%	100.0%
2) Durable Health Care Power of Attorney	35.3%	63.3%	90.0%
3) Eligibility for Medicaid	44.4%	53.1%	58.5%
4) Legal and financial consequences of AD	55.3%	93.9%	95.1%
5) Using Health Care Power of Attorney	82.9%	93.9%	100.0%
6) Notorizing General Power of Attorney	67.5%	85.3%	87.8%

[*] Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 16. Item Analysis for Caregiver Knowledge Test* Module 7: Managing the Daily Routine

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Facilitating the task of dressing	45.9%	78.9%	100.0%
2) Calorie requirement of older persons	67.6%	68.4%	95.3%
3) Definition of Apraxia	42.4%	62.5%	88.0%
4) Inadviseability of using bath oil	25.6%	73.7%	83.7%
5) Inadviseability of changing the daily routine	29.7%	83.8%	95.3%
6) Inability to gauge temperature	84.6%	94.7%	100.0%
7) Complex grooming activities	61.5%	86.5%	90.7%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 17. Item Analysis for Caregiver Knowledge Test* Module 12: Formal Supports and Resources

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Calling for formal assistance	48.5%	90.6%	97.6%
2) Medicare Part B coverage	19.4%	48.6%	68.3%
3) Rural AAA's budgets and staff	45.5%	72.7%	92.7%
4) Dictates of the Older Americans Act	91.7%	97.1%	100.0%
5) Virginia Long Term Care Council	72.2%	93.9%	100.0%
6) Local Alzheimer's Association Chapter	66.7%	88.6%	92.9%
7) Medicaid vs. Medicare Coverage	58.3%	68.6%	81.0%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 18. Item Analysis for Caregiver Knowledge Test*
Module 14: Managing Resistive Behavior

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Reasons for resistance to bathing	56.7%	79.3%	92.3%
2) Stages of AD when incontinence occurs	61.3%	79.3%	88.5%
3) Dealing with ADL difficulties	56.3%	75.9%	100.0%
4) Restricted water intake for incontinence	51.6%	60.7%	92.0%
5) Dealing with mealtime difficulties	63.3%	96.4%	100.0%
6) Dressing/grooming and self-esteem	90.3%	100.0%	100.0%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 19. Item Analysis for Caregiver Knowledge Test*
Module 16: Communicating with the Patient

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Definition of aphasia	48.3%	78.6%	92.3%
2) Dementia-related language problems	34.5%	46.4%	62.5%
3) Understanding vs. communicating	44.8%	59.3%	80.8%
4) Inadviseability of "baby talk"	86.2%	96.6%	96.0%
5) Reducing background noise	89.7%	93.1%	100.0%
6) Importance of talking to the patient	89.7%	96.6%	100.0%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 20. Item Analysis for Caregiver Knowledge Test*
Module 21: 24 Hour Care

Knowledge Test Item	Low (n=57)	Moderate (n=59)	High (n=58)
1) Cost of institutional care of AD patient	25.0%	65.4%	76.9%
2) Health team members in nursing home	81.3%	86.2%	100.0%
3) Making the placement decision	87.1%	96.7%	100.0%
4) Importance of geographical proximity	83.3%	89.7%	100.0%
5) Advantage of structured environment	84.4%	89.7%	92.3%
6) Caregiver participation in care plan	70.0%	86.2%	96.0%
7) Making the adjustment to placement	71.0%	80.0%	100.0%

* Percentages refer to proportion of participants in each scoring group answering item correctly

TABLE 21. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 1: Overview of Dementia and Alzheimer's Disease*

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Definition of Dementia*	.01 level	Ideal
2) Definition of Alzheimer's Disease*	.01 level	Partial
3) Most conclusive diagnostic method	.01 level	Too Easy
4) Primary symptoms of AD in early stages	.025 level	Too Easy
5) AD as diagnosis of exclusion*	.025 level	Ideal
6) Brain cell deterioration in AD	.01 level	Too Easy
7) Duration of Alzheimer's Disease*	No	Partial
8) Gradual onset of Alzheimer's Disease*	No	Linear

* Items were retained for revised tests

TABLE 22. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 2: Caregiver Burden

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Roles of the effective caregiver*	.01 Level	Linear
2) Major components of caregiver burnout	.01 Level	Too Difficult
3) Definition of depersonalization*	.025 Level	Partial
4) Definition of caregiver burnout*	No	Partial
5) Basic goal of caregiving	No	Too Easy
6) Most frequent type of maltreatment	No	Too Difficult
7) Prevalence of caregiver depression	No	Too Easy

* Items were retained for revised tests

TABLE 23. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 3: Coping with Stress

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Kinds of respite*	No	Ideal
2) Definition of Eustress*	.01 Level	Linear
3) Defintion of "fight or flight" syndrome*	No	Linear
4) Symptoms of stress*	.01 Level	Linear
5) Definition of progressive relaxation*	.01 Level	Partial

* Items were retained for revised tests

TABLE 24. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 5: Legal and Financial Issues

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Examples of advance directives*	No	Linear
2) Durable Health Care Power of Attorney*	.01 Level	Ideal
3) Eligibility for Medicaid	No	Too Difficult
4) Legal and financial consequences of AD	No	Partial
5) Using Health Care Power of Attorney	.01 Level	Too Easy
6) Notorizing General Power of Attorney*	.01 Level	Partial

* Items were retained for revised tests

TABLE 25. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 7: Managing the Daily Routine

Knowledge Test Item	Statistical Comparisons	Results of Item Analysis
1) Facilitating the task of dressing*	.01 Level	Linear
2) Calorie requirement of older persons*	.01 Level	Partial
3) Definition of Apraxia*	.01 Level	Ideal
4) Inadviseability of using bath oil *	.01 Level	Linear
5) Inadviseability of changing the daily routine*	.01 Level	Partial
6) Inability to gauge temperature	.025 Level	Too Easy
7) Complex grooming activities*	No	Linear

* Items were retained for revised tests

TABLE 26. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 12: Formal Supports and Resources

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Calling for formal assistance*	.01 Level	Partial
2) Medicare Part B coverage*	.01 Level	Ideal
3) Rural AAA's budgets and staff*	No	Linear
4) Dictates of the Older Americans Act	No	Too Easy
5) Virginia Long Term Care Council*	.01 Level	Partial
6) Local Alzheimer's Association Chapter*	No	Linear
7) Medicaid vs. Medicare Coverage*	No	Linear

* Items were retained for revised tests

TABLE 27. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 14: Managing Resistive Behavior

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Reasons for resistance to bathing*	No	Linear
2) Stages of AD when incontinence occurs*	.01 Level	Linear
3) Dealing with ADL difficulties*	.025 Level	Linear
4) Restricted water intake for incontinence*	No	Linear
5) Dealing with mealtime difficulties*	No	Partial
6) Dressing/grooming and self-esteem	No	Too Easy

* Items retained for revised tests

TABLE 28. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 16: Communicating with the Patient

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Definition of aphasia*	No	Linear
2) Dementia-related language problems	.01 Level	Too Difficult
3) Understanding vs. communicating*	.01 Level	Ideal
4) Inadviseability of "baby talk"	.01 Level	Too Easy
5) Reducing background noise	.01 Level	Too Easy
6) Importance of talking to the patient	No	Too Easy

* Items were retained for revised tests

TABLE 29. Results of Item Analysis and Pre-Workshop Post-Workshop Performance Comparisons
Module 21: 24 Hour Care

Knowledge Test Item	Statistical Significance	Results of Item Analysis
1) Cost of institutional care of AD patient*	No	Ideal
2) Health team members in nursing home	.025 Level	Too Easy
3) Making the placement decision	.01 Level	Too Easy
4) Importance of geographical proximity	.025 Level	Too Easy
5) Advantage of structured environment	No	Too Easy
6) Caregiver participation in care plan*	.01 Level	Linear
7) Making the adjustment to placement*	No	Linear

* Items were retained for revised tests

TABLE 30. Demographic Characteristics of Caregivers Responding to Evaluation Questionnaire (N=165)

Demographic Category	n	%
Ethnicity of Participants		
African American	118	72.0%
Caucasian	41	25.0%
Other	5	3.0%
Gender of Participants		
Male	25	15.2%
Female	139	84.8%
Place of Residence		
Rural	114	69.9%
Urban	26	16.0%
Suburban	23	14.1%

TABLE 31. Results of Evaluation Questionnaire Completed By Caregivers (N=165)*

Evaluation Question	Mean	Std. Dev.	n
Trainer Effectiveness	4.49	0.78	126
Usefulness of Material Presented	4.36	0.75	141
Learned to Be a Better Caregiver	4.17	0.80	144
Material Relevant to Personal Problems/Concerns	4.15	0.87	163
Gained Better Understanding of How Care Recipient Feels	4.12	0.81	162
Gained Better Understanding of How to Help Care Recipient Live a Happier Life	4.06	0.77	144
Gained Better Understanding of Personal Feelings About Care Recipient	4.05	0.90	161
More Aware of Help Available in Community	3.98	0.83	164
More Likely to Use Community Resources	3.87	0.95	159

* Items rated on 5-point Likert scale

APPENDIX VIII-A

MODULE 1: OVERVIEW OF DEMENTIA AND ALZHEIMER'S DISEASE

PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

2. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

3. The most conclusive method of diagnosing Alzheimer's Disease:
   a. is accomplished through a CAT scan.
   b. is based on the results of IQ tests.
   c. can be made only upon examination of brain tissue at autopsy.

4. ____________________ is the primary symptom of Alzheimer's Disease in the early stages.
   a. Violent outbursts
   b. Forgetfulness
   c. Wandering
   d. Seeing things that aren't there

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. Alzheimer's Disease is diagnosed by excluding other possible causes.

_____ 6. Alzheimer's Disease causes cells in the brain to die.

_____ 7. Alzheimer's Disease can last from two to twenty years.

_____ 8. The onset of Alzheimer's Disease is usually very sudden rather than gradual.

MODULE 1: OVERVIEW OF DEMENTIA AND ALZHEIMER'S DISEASE
POST-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

2. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

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   a. is accomplished through a CAT scan.
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   a. Violent outbursts
   b. Forgetfulness
   c. Wandering
   d. Seeing things that aren't there

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. Alzheimer's Disease is diagnosed by excluding other possible causes.

_____ 6. Alzheimer's Disease causes cells in the brain to die.

_____ 7. Alzheimer's Disease can last from two to twenty years.

_____ 8. The onset of Alzheimer's Disease is usually very sudden rather than gradual.

MODULE 2: CAREGIVER BURDEN
PRE-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The effective caregiver fills all of the following roles except:
   a. manager.
   b. enabler.
   c. learner.
   d. observer.

2. Which of the following is not one of the three major components of caregiver "burnout"?
   a. emotional exhaustion
   b. physical exhaustion
   c. reduced personal accomplishments
   d. depersonalization

3. The development of a negative and insensitive attitude about the patient is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

4. The physical, financial, and emotional stress of caring for a disabled elderly family member is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. The basic goal of caregiving is to ensure the patient's comfort and safety, while promoting emotional stability and self-esteem.

_____ 6. Abuse by a caregiver is the most frequent type of maltreatment of older and incapacitated adults.

_____ 7. As many as 65% of family caregivers experience symptoms of depression.

MODULE 2: CAREGIVER BURDEN
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The effective caregiver fills all of the following roles except:
   a. manager.
   b. enabler.
   c. learner.
   d. observer.

2. Which of the following is not one of the three major components of caregiver "burnout"?
   a. emotional exhaustion
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4. The physical, financial, and emotional stress of caring for a disabled elderly family member is called:
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   b. caregiver burnout
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In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. The basic goal of caregiving is to ensure the patient's comfort and safety, while promoting emotional stability and self-esteem.

_____ 6. Abuse by a caregiver is the most frequent type of maltreatment of older and incapacitated adults.

_____ 7. As many as 65% of family caregivers experience symptoms of depression.

MODULE 3: COPING WITH STRESS
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Caregivers can get respite or relief from their caregiving responsibilities by:
   a. finding adult day care.
   b. hiring a homecare aide.
   c. having someone else stay with the care recipient for a few hours.
   d. retreat to a "hermit spot" or "quiet hideout."
   e. all of the above.

2. ____________ is the invigorating and challenging kind of stress, while distress is the negative kind of stress to be avoided.
   a. Eustress
   b. Mistress
   c. Unstress
   d. Envirostress

3. The _________________________ syndrome occurs when the body reacts to threat and prepares to either confront of escape it.
   a. mea culpa
   b. give or take
   c. fight or flight
   d. make or break

4. All of the following are symptoms that indicate stress, except:
   a. dry palms and warm hands
   b. pounding heart
   c. nightmares
   d. change in appetite

5. ____________ is a stress-relieving technique based on the theory that tense muscles are the body's response to anxiety.
   a. Visualization or guided imagery
   b. Progressive relaxation
   c. Deep abdominal breathing

MODULE 3: COPING WITH STRESS
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Caregivers can get respite or relief from their caregiving responsibilities by:
   a. finding adult day care.
   b. hiring a homecare aide.
   c. having someone else stay with the care recipient for a few hours.
   d. retreat to a "hermit spot" or "quiet hideout."
   e. all of the above.

2. ____________ is the invigorating and challenging kind of stress, while distress is the negative kind of stress to be avoided.
   a. Eustress
   b. Mistress
   c. Unstress
   d. Envirostress

3. The ________________________ syndrome occurs when the body reacts to threat and prepares to either confront of escape it.
   a. mea culpa
   b. give or take
   c. fight or flight
   d. make or break

4. All of the following are symptoms that indicate stress, except:
   a. dry palms and warm hands
   b. pounding heart
   c. nightmares
   d. change in appetite

5. ___________ is a stress-relieving technique based on the theory that tense muscles are the body's response to anxiety.
   a. Visualization or guided imagery
   b. Progressive relaxation
   c. Deep abdominal breathing

MODULE 5: LEGAL AND FINANCIAL ISSUES
PRE-TEST QUESTIONS

Caregiver Identification Number____________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Examples of advance directives are:
    a. will
    b. Health Care Power of Attorney (medical affairs)
    c. General Power of Attorney (financial affairs)
    d. all of the above.

2. A durable health care power of attorney:
    a. will still be valid after a person becomes incapacitated.
    b. must be witnessed by at least one blood relative.
    c. must be notarized.
    d. must be drawn up by an attorney.

3. To determine your eligibility for Medicaid you must:
    a. contact your local Social Services Department to begin the process.
    b. have documentation (checks, bank statements, tax returns, etc.) of your financial dealings for the previous 30-36 months.
    c. "spend down" to no more than $1,500 left for yourself.
    d. all of the above.

4. Some of the legal and financial consequences of Alzheimer's Disease include the fact that the person with Alzheimer's Disease eventually:
    a. will not be able to handle financial and business affairs.
    b. will not be able to make his/her own health care decisions.
    c. will have to use his own savings to cover necessary help that is not covered by insurance.
    d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. You can use a standard form for a durable Health Care Power of Attorney by signing it in the presence of two witnesses (not blood related).

_____ 6. A durable General Power of Attorney must be notarized but a Health Care Power of Attorney does not have to be.

MODULE 5: LEGAL AND FINANCIAL ISSUES
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Examples of advance directives are:
   a. will
   b. Health Care Power of Attorney (medical affairs)
   c. General Power of Attorney (financial affairs))
   d. all of the above.

2. A durable health care power of attorney:
   a. will still be valid after a person becomes incapacitated.
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   b. will not be able to make his/her own health care decisions.
   c. will have to use his own savings to cover necessary help that is not covered by insurance.
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In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 5. You can use a standard form for a durable Health Care Power of Attorney by signing it in the presence of two witnesses (not blood-related).

_____ 6. A durable General Power of Attorney must be notarized but a durable Health Care Power of Attorney does not have to be.

MODULE 7: MANAGING THE DAILY ROUTINE
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The task of dressing the person with dementia can best be facilitated by:
   a. taking over the task if the person is too slow.
   b. offering several choices of clothing.
   c. laying out articles of clothing in the order they are to be put on.
   d. all of the above.

2. The calorie requirements of an older person are ________________ the calorie requirements of a younger person.
   a. the same as
   b. greater than
   c. less than

3. ____________ is a series of mixed messages sent from the brain to the body.
   a. Apraxia
   b. Apoxia
   c. Dispraxia
   d. Dispoxia

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. Using bath oil or bubble bath is a good idea because it can make the bathing experience more enjoyable.

_____ 5. When patient's resist assistance with Activities of Daily Living, it is recommended that caregivers change the daily routine as much as possible.

_____ 6. Persons with Alzheimer's Disease or other dementias lose the ability to gauge temperature and sense hot or cold.

_____ 7. Since grooming activities such as shaving and brushing teeth are not complex, they are easily performed by persons with Alzheimer's Disease or other dementias.

MODULE 7: MANAGING THE DAILY ROUTINE
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The task of dressing the person with dementia can best be facilitated by:
   a. taking over the task if the person is too slow.
   b. offering several choices of clothing.
   c. laying out articles of clothing in the order they are to be put on.
   d. all of the above.

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   b. greater than
   c. less than

3. ____________ is a series of mixed messages sent from the brain to the body.
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   b. Apoxia
   c. Dispraxia
   d. Dispoxia

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_____ 7. Since grooming activities such as shaving and brushing teeth are not complex, they are easily performed by persons with Alzheimer's Disease or other dementias.

MODULE 12: FORMAL SUPPORTS AND RESOURCES
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. When calling to find formal assistance with caregiving responsibilities caregivers should do all of the following, except:
   a. try to call in the late afternoon.
   b. be specific about the service you want.
   c. be polite, but firm.
   d. get the name of everyone you talk to.
   e. be prepared for the intake interview.

2. Medicare Part B helps pay for all of the following, except:
   a. physician services.
   b. inpatient hospital care.
   c. outpatient mental health services.
   d. mammography screening every other year.

3. Rural Area Agencies on Aging typically have budgets and staff which are ________________ Area Agencies on Aging in urban areas.
   a. larger than
   b. smaller than
   c. the same size as

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. The Older Americans Act dictates that the elderly have certain rights and privileges that should be provided for by national, state, and local governments.

_____ 5. The Virginia Long Term Care Council supports the development of community-based resources to avoid the inappropriate institutionalization of impaired elders.

_____ 6. Your local Alzheimer's Disease chapter does not provide services to patients until they are in the middle or late stages of the disease.

_____ 7. If you are eligible for Medicaid because of low income, you will have benefits that are not provided for by Medicare insurance.

MODULE 12: FORMAL SUPPORTS AND RESOURCES
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. When calling to find formal assistance with caregiving responsibilities caregivers should do all of the following, except:
   a. try to call in the late afternoon.
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_____ 7. If you are eligible for Medicaid because of low income, you will have benefits that are not provided for by Medicare insurance.

MODULE 14: MANAGING RESISTIVE BEHAVIOR
PRE-TEST QUESTIONS

Caregiver Identification Number______________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Persons with dementia may resist bathing because they:
   a. are depressed.
   b. fear water.
   c. are embarrassed to be undressed.
   d. all of the above.

2. Incontinence of bowel and/or bladder is common among Alzheimer's patients during ____________ stages of the disease.
   a. the earlier
   b. the middle
   c. the later
   d. all

3. When patients have trouble performing Activities of Daily Living, it's a good idea to:
   a. insist that they let you do things for them even if they are capable.
   b. give them a detailed list of instructions to follow.
   c. observe their attempts to perform the activities and provide cues when needed.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. One way to cope with incontinence is to restrict water intake to three cups of liquid per day.

_____ 5. Laying out a wide variety of different foods on the table at mealtime will help with mealtime difficulties.

_____ 6. Proper dressing and grooming is important to fostering the patient's self esteem.

MODULE 14: MANAGING RESISTIVE BEHAVIOR
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Persons with dementia may resist bathing because they:
   a. are depressed.
   b. fear water.
   c. are embarrassed to be undressed.
   d. all of the above.

2. Incontinence of bowel and/or bladder is common among Alzheimer's patients during ____________ stages of the disease.
   a. the earlier
   b. the middle
   c. the later
   d. all

3. When patients have trouble performing Activities of Daily Living, it's a good idea to:
   a. insist that they let you do things for them even if they are capable.
   b. give them a detailed list of instructions to follow.
   c. observe their attempts to perform the activities and provide cues when needed.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. One way to cope with incontinence is to restrict water intake to three cups of liquid per day.

_____ 5. Laying out a wide variety of different foods on the table at mealtime will help with mealtime difficulties.

_____ 6. Proper dressing and grooming is important to fostering the patient's self esteem.

MODULE 16: COMMUNICATING WITH THE PATIENT
PRE-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Aphasia refers to an inability to:
   a. express thoughts in language.
   b. understand the spoken word.
   c. recognize a word or phrase.
   d. all of the above.

2. A person with dementia may exhibit all of the following language problems, except:
   a. stuttering.
   b. misnomia.
   c. aphasia.
   d. perseveration.

3. A person with dementia loses the ability to understand what you are saying:
   a. long after they have lost the ability to communicate coherently.
   b. at the same time they lose the ability to communicate coherently.
   c. long before they have lost the ability to communicate coherently.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. Using "baby talk" is helpful when communicating with a person with dementia who is experiencing language difficulty.

_____ 5. Reducing background noise may help when communicating with a person with dementia who is experiencing language difficulty.

_____ 6. Even when it seems that you are not getting through to the patient, it's important to keep talking to them.

MODULE 16: COMMUNICATING WITH THE PATIENT
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Aphasia refers to an inability to:
   - a. express thoughts in language.
   - b. understand the spoken word.
   - c. recognize a word or phrase.
   - d. all of the above.

2. A person with dementia may exhibit all of the following language problems, except:
   - a. stuttering.
   - b. misnomia.
   - c. aphasia.
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   - a. long after they have lost the ability to communicate coherently.
   - b. at the same time they lose the ability to communicate coherently.
   - c. long before they have lost the ability to communicate coherently.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

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_____ 5. Reducing background noise may help when communicating with a person with dementia who is experiencing language difficulty.

_____ 6. Even when it seems that you are not getting through to the patient, it's important to keep talking to them.

MODULE 21: 24 HOUR CARE
PRE-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. According to a recent study conducted by the University of California, caring for an institutionalized patient with Alzheimer's Disease costs about:
   a. $25,000 a year.
   b. $50,000 a year.
   c. $75,000 a year.
   d. $100,000 a year.

2. The member of the health team who spends more time with the patient than anyone else is the:
   a. nursing home administrator.
   b. activity director.
   c. nurse aide.
   d. physical therapist.
   e. occupational therapist.

3. The decision about when nursing home placement is appropriate should be made by:
   a. the caregiver alone.
   b. the patient alone.
   c. the entire family.
   d. the nursing home staff.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. Geographical proximity is of primary importance when evaluating placement options.

_____ 5. Many Alzheimer's patients do better in a structured environment with caring professionals to provide physical, emotional, and social care.

_____ 6. The family caregiver is usually discouraged from participating in care plan conferences when a nursing home placement is made.

_____ 7. The person with Alzheimer's adjusts better to nursing home placement if there are no reminders of home.

MODULE 21: 24 HOUR CARE
POST-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. According to a recent study conducted by the University of California, caring for an institutionalized patient with Alzheimer's Disease costs about:
   a. $25,000 a year.
   b. $50,000 a year.
   c. $75,000 a year.
   d. $100,000 a year.

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   a. nursing home administrator.
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_____ 5. Many Alzheimer's patients do better in a structured environment with caring professionals to provide physical, emotional, and social care.

_____ 6. The family caregiver is usually discouraged from participating in care plan conferences when a nursing home placement is made.

_____ 7. The person with Alzheimer's adjusts better to nursing home placement if there are no reminders of home.

APPENDIX VIII-B

MODULE 1: OVERVIEW OF DEMENTIA AND ALZHEIMER'S DISEASE
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Dementia is:
   - a. the same as senility.
   - b. a normal part of aging.
   - c. a loss of intellectual ability that interferes with daily functioning.
   - d. all of the above.

2. Alzheimer's Disease is:
   - a. an age-related, chronic cognitive dysfunction.
   - b. the most common form of dementia.
   - c. a progressive, degenerative brain disease.
   - d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 3. Alzheimer's Disease is diagnosed by excluding other possible causes.

_____ 4. Alzheimer's Disease can last from two to twenty years.

_____ 5. The onset of Alzheimer's Disease is usually very sudden rather than gradual.

MODULE 1: OVERVIEW OF DEMENTIA AND ALZHEIMER'S DISEASE
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Dementia is:
   a. the same as senility.
   b. a normal part of aging.
   c. a loss of intellectual ability that interferes with daily functioning.
   d. all of the above.

2. Alzheimer's Disease is:
   a. an age-related, chronic cognitive dysfunction.
   b. the most common form of dementia.
   c. a progressive, degenerative brain disease.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 3. Alzheimer's Disease is diagnosed by excluding other possible causes.

_____ 4. Alzheimer's Disease can last from two to twenty years.

_____ 5. The onset of Alzheimer's Disease is usually very sudden rather than gradual.

MODULE 2: CAREGIVER BURDEN
PRE-TEST QUESTIONS

Caregiver Identification Number______________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The effective caregiver fills all of the following roles except:
   a. manager.
   b. enabler.
   c. learner.
   d. observer.

2. The development of a negative and insensitive attitude about the patient is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

3. The physical, financial, and emotional stress of caring for a disabled elderly family member is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

MODULE 2: CAREGIVER BURDEN
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The effective caregiver fills all of the following roles except:
   a. manager.
   b. enabler.
   c. learner.
   d. observer.

2. The development of a negative and insensitive attitude about the patient is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

3. The physical, financial, and emotional stress of caring for a disabled elderly family member is called:
   a. caregiver burden
   b. caregiver burnout
   c. depersonalization
   d. the mea culpa syndrome

MODULE 3: COPING WITH STRESS
PRE-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Caregivers can get respite or relief from their caregiving responsibilities by:
   a. finding adult day care.
   b. hiring a homecare aide.
   c. having someone else stay with the care recipient for a few hours.
   d. retreat to a "hermit spot" or "quiet hideout."
   e. all of the above.

2. ____________ is the invigorating and challenging kind of stress, while distress is the negative kind of stress to be avoided.
   a. Eustress
   b. Mistress
   c. Unstress
   d. Envirostress

3. The ________________________ syndrome occurs when the body reacts to threat and prepares to either confront of escape it.
   a. mea culpa
   b. give or take
   c. fight or flight
   d. make or break

4. All of the following are symptoms that indicate stress, except:
   a. dry palms and warm hands
   b. pounding heart
   c. nightmares
   d. change in appetite

5. ___________ is a stress-relieving technique based on the theory that tense muscles are the body's response to anxiety.
   a. Visualization or guided imagery
   b. Progressive relaxation
   c. Deep abdominal breathing

MODULE 3: COPING WITH STRESS
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Caregivers can get respite or relief from their caregiving responsibilities by:
   a. finding adult day care.
   b. hiring a homecare aide.
   c. having someone else stay with the care recipient for a few hours.
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   e. all of the above.

2. ____________ is the invigorating and challenging kind of stress, while distress is the negative kind of stress to be avoided.
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   b. Mistress
   c. Unstress
   d. Envirostress

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   a. mea culpa
   b. give or take
   c. fight or flight
   d. make or break

4. All of the following are symptoms that indicate stress, except:
   a. dry palms and warm hands
   b. pounding heart
   c. nightmares
   d. change in appetite

5. ___________ is a stress-relieving technique based on the theory that tense muscles are the body's response to anxiety.
   a. Visualization or guided imagery
   b. Progressive relaxation
   c. Deep abdominal breathing

MODULE 5: LEGAL AND FINANCIAL ISSUES
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Examples of advance directives are:
   a. will
   b. Health Care Power of Attorney (medical affairs)
   c. General Power of Attorney (financial affairs)
   d. all of the above.

2. A durable health care power of attorney:
   a. will still be valid after a person becomes incapacitated.
   b. must be witnessed by at least one blood relative.
   c. must be notarized.
   d. must be drawn up by an attorney.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 3. A durable General Power of Attorney must be notarized but a Health Care Power of Attorney does not have to be.

MODULE 5: LEGAL AND FINANCIAL ISSUES
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Examples of advance directives are:
    a. will
    b. Health Care Power of Attorney (medical affairs)
    c. General Power of Attorney (financial affairs))
    d. all of the above.

2. A durable health care power of attorney:
    a. will still be valid after a person becomes incapacitated.
    b. must be witnessed by at least one blood relative.
    c. must be notarized.
    d. must be drawn up by an attorney.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 3. A durable General Power of Attorney must be notarized but a durable Health Care Power of Attorney does not have to be.

MODULE 7: MANAGING THE DAILY ROUTINE
PRE-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The task of dressing the person with dementia can best be facilitated by:
   a. taking over the task if the person is too slow.
   b. offering several choices of clothing.
   c. laying out articles of clothing in the order they are to be put on.
   d. all of the above.

2. The calorie requirements of an older person are ________________ the calorie requirements of a younger person.
   a. the same as
   b. greater than
   c. less than

3. ____________ is a series of mixed messages sent from the brain to the body.
   a. Apraxia
   b. Apoxia
   c. Dispraxia
   d. Dispoxia

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. Using bath oil or bubble bath is a good idea because it can make the bathing experience more enjoyable.

_____ 5. When patient's resist assistance with Activities of Daily Living, it is recommended that caregivers change the daily routine as much as possible.

_____ 6. Since grooming activities such as shaving and brushing teeth are not complex, they are easily performed by persons with Alzheimer's Disease or other dementias.

MODULE 7: MANAGING THE DAILY ROUTINE
POST-TEST QUESTIONS

Caregiver Identification Number____________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. The task of dressing the person with dementia can best be facilitated by:
   a. taking over the task if the person is too slow.
   b. offering several choices of clothing.
   c. laying out articles of clothing in the order they are to be put on.
   d. all of the above.

2. The calorie requirements of an older person are ________________ the calorie requirements of a younger person.
   a. the same as
   b. greater than
   c. less than

3. ____________ is a series of mixed messages sent from the brain to the body.
   a. Apraxia
   b. Apoxia
   c. Dispraxia
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In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

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_____ 5. When patient's resist assistance with Activities of Daily Living, it is recommended that caregivers change the daily routine as much as possible.

_____ 6. Since grooming activities such as shaving and brushing teeth are not complex, they are easily performed by persons with Alzheimer's Disease or other dementias.

MODULE 12: FORMAL SUPPORTS AND RESOURCES
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. When calling to find formal assistance with caregiving responsibilities caregivers should do all of the following, except:
   a. try to call in the late afternoon.
   b. be specific about the service you want.
   c. be polite, but firm.
   d. get the name of everyone you talk to.
   e. be prepared for the intake interview.

2. Medicare Part B helps pay for all of the following, except:
   a. physician services.
   b. inpatient hospital care.
   c. outpatient mental health services.
   d. mammography screening every other year.

3. Rural Area Agencies on Aging typically have budgets and staff which are ________________ Area Agencies on Aging in urban areas.
   a. larger than
   b. smaller than
   c. the same size as

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. The Virginia Long Term Care Council supports the development of community-based resources to avoid the inappropriate institutionalization of impaired elders.

_____ 5. Your local Alzheimer's Disease chapter does not provide services to patients until they are in the middle or late stages of the disease.

_____ 6. If you are eligible for Medicaid because of low income, you will have benefits that are not provided for by Medicare insurance.

MODULE 12: FORMAL SUPPORTS AND RESOURCES
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. When calling to find formal assistance with caregiving responsibilities caregivers should do all of the following, except:
   a. try to call in the late afternoon.
   b. be specific about the service you want.
   c. be polite, but firm.
   d. get the name of everyone you talk to.
   e. be prepared for the intake interview.

2. Medicare Part B helps pay for all of the following, except:
   a. physician services.
   b. inpatient hospital care.
   c. outpatient mental health services.
   d. mammography screening every other year.

3. Rural Area Agencies on Aging typically have budgets and staff which are ________________ Area Agencies on Aging in urban areas.
   a. larger than
   b. smaller than
   c. the same size as

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. The Virginia Long Term Care Council supports the development of community-based resources to avoid the inappropriate institutionalization of impaired elders.

_____ 5. Your local Alzheimer's Disease chapter does not provide services to patients until they are in the middle or late stages of the disease.

_____ 6. If you are eligible for Medicaid because of low income, you will have benefits that are not provided for by Medicare insurance.

MODULE 14: MANAGING RESISTIVE BEHAVIOR
PRE-TEST QUESTIONS

Caregiver Identification Number____________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Persons with dementia may resist bathing because they:
   a. are depressed.
   b. fear water.
   c. are embarrassed to be undressed.
   d. all of the above.

2. Incontinence of bowel and/or bladder is common among Alzheimer's patients during ____________ stages of the disease.
   a. the earlier
   b. the middle
   c. the later
   d. all

3. When patients have trouble performing Activities of Daily Living, it's a good idea to:
   a. insist that they let you do things for them even if they are capable.
   b. give them a detailed list of instructions to follow.
   c. observe their attempts to perform the activities and provide cues when needed.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. One way to cope with incontinence is to restrict water intake to three cups of liquid per day.

_____ 5. Laying out a wide variety of different foods on the table at mealtime will help with mealtime difficulties.

MODULE 14: MANAGING RESISTIVE BEHAVIOR
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Persons with dementia may resist bathing because they:
   a. are depressed.
   b. fear water.
   c. are embarrassed to be undressed.
   d. all of the above.

2. Incontinence of bowel and/or bladder is common among Alzheimer's patients during ____________ stages of the disease.
   a. the earlier
   b. the middle
   c. the later
   d. all

3. When patients have trouble performing Activities of Daily Living, it's a good idea to:
   a. insist that they let you do things for them even if they are capable.
   b. give them a detailed list of instructions to follow.
   c. observe their attempts to perform the activities and provide cues when needed.
   d. all of the above.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 4. One way to cope with incontinence is to restrict water intake to three cups of liquid per day.

_____ 5. Laying out a wide variety of different foods on the table at mealtime will help with mealtime difficulties.

MODULE 16: COMMUNICATING WITH THE PATIENT
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Aphasia refers to an inability to:
   a. express thoughts in language.
   b. understand the spoken word.
   c. recognize a word or phrase.
   d. all of the above.

2. A person with dementia loses the ability to understand what you are saying:
   a. long after they have lost the ability to communicate coherently.
   b. at the same time they lose the ability to communicate coherently.
   c. long before they have lost the ability to communicate coherently.

MODULE 16: COMMUNICATING WITH THE PATIENT
POST-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. Aphasia refers to an inability to:
   - a. express thoughts in language.
   - b. understand the spoken word.
   - c. recognize a word or phrase.
   - d. all of the above.

2. A person with dementia may exhibit all of the following language problems, except:
   - a. stuttering.
   - b. misnomia.
   - c. aphasia.
   - d. perseveration.

MODULE 21: 24 HOUR CARE
PRE-TEST QUESTIONS

Caregiver Identification Number____

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. According to a recent study conducted by the University of California, caring for an institutionalized patient with Alzheimer's Disease costs about:
   a. $25,000 a year.
   b. $50,000 a year.
   c. $75,000 a year.
   d. $100,000 a year.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 2. The family caregiver is usually discouraged from participating in care plan conferences when a nursing home placement is made.

_____ 3. The person with Alzheimer's adjusts better to nursing home placement if there are no reminders of home.

MODULE 21: 24 HOUR CARE
POST-TEST QUESTIONS

Caregiver Identification Number________________________________

For each of the items which follow, circle the letter beside the best answer. Be sure to respond to each item. If you aren't sure, make your best guess.

1. According to a recent study conducted by the University of California, caring for an institutionalized patient with Alzheimer's Disease costs about:
   a. $25,000 a year.
   b. $50,000 a year.
   c. $75,000 a year.
   d. $100,000 a year.

In the space provided beside each item write the words "True" or "False" to indicate whether you think the statement is true or false.

_____ 2. The family caregiver is usually discouraged from participating in care plan conferences when a nursing home placement is made.

_____ 3. The person with Alzheimer's adjusts better to nursing home placement if there are no reminders of home.

APPENDIX VIII-C

Workshop Evaluation Questionnaire
Workshop Number ____

Caregiver Identification Number________________________________

Please take a few minutes to answer the following questionnaire. We want to find out if this workshop was helpful to you and discover ways to make it more beneficial in the future. There are no right or wrong answers and your responses will remain confidential. You will not be identified personally in any way.

1. What is your gender? Male Female

2. What is your racial background?

White Black Other________________________
(please specify)

3. Where do you live? Rural area Urban area Suburban area

Use the scale which follows and place the number that corresponds with your answer in the blank beside each question.

1 = Not at all
2 = A little
3 = Somewhat
4 = A lot
5 = Extremely

_____ 4. Was the material covered in this workshop relevant to your particular problems and concerns as a caregiver?

_____ 5. Did attending this workshop make you more aware of help that is available in the community (that is, service agencies and organizations)?

_____ 6. After attending this workshop are you more likely to use help that is available in the community (for example, your local Alzheimer's Association or Area Agency on Aging)?

_____ 7. Did attending this workshop provide you with a better understanding of how the person you care for feels?

_____ 8. Did attending this workshop provide you with a better understanding of how you feel about the person you care for?

1 = Not at all
2 = A little
3 = Somewhat
4 = A lot
5 = Extremely

_____ 9. Did attending this workshop provide you with a better understanding of how you can help the person you care for live a happier life?

_____ 10. After attending this workshop do you feel that you have learned some things that will help you be a better caregiver?

_____ 11. In general, how useful did you find the material presented in this workshop?

_____ 12. Overall, how effective do you think the trainer was in communicating the material covered?

13. Did the trainer distribute any handout material for you to keep?

Yes No

_____ If yes, how useful did you find this handout material (use the scale above)?

14. Did the trainer show any videos?

Yes No

_____ If yes, how useful did you find the videos (use the scale above)?

15. What was the most helpful aspect of this workshop?

____

____

____

14. What was the least helpful aspect of this workshop?

____

____

____

ORDER FORM

Name ____
Address ______________________________________
____
Daytime Phone (_____) ____________________

Please send:

___ copy(ies) of Families Who Care ($15.00 ea.)
___ copy(ies) of Replication Plan ($5.00 ea.) ______
___ copy(ies) of Final Report ($25.00 ea.) ______
___ diskette(s) of the *National* Directory of Resources ($10.00 ea.) ______
___ diskette(s) of the *Virginia* Directory of Resources ($10.00 ea.) ______
Total: ______

PREPAYMENT (check, money order, or requisition is required,
payable to: VIRGINIA COMMONWEALTH UNIVERSITY

Mail to:
Caregiver Project
c/o Virginia Center on Aging
Box 980229
Richmond, Virginia 23298-0229

(ALLOW 6-8 WEEKS FOR DELIVERY)

- -

ORDER FORM

Name ____
Address ______________________________________
____
Daytime Phone (_____) ____________________

Please send:

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___ copy(ies) of Replication Plan ($5.00 ea.) ______
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Total: ______

PREPAYMENT (check, money order, or requisition is required,
payable to: VIRGINIA COMMONWEALTH UNIVERSITY

Mail to:
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c/o Virginia Center on Aging
Box 980229
Richmond, Virginia 23298-0229

(ALLOW 6-8 WEEKS FOR DELIVERY)

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